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Alternative Health Care Delivery Model for Leon County's Uninsured Initiative

MERCER
Government Human Services Consulting

MMC Marsh & McLennan Companies

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Executive Summary

Leon County (County) has a history of striving to provide medical care to its uninsured residents. Community collaboration has been key to this effort. While the County already has the lowest rate of uninsured residents in the State of Florida (State), Leon County continues to look for ways to further increase coverage to all residents. If successful in this endeavor, the County should reap the rewards of health care coverage for its citizens by accomplishing the following:

- Meeting the basic health care needs for all County residents;
- Increasing the health of the population, thus increasing work productivity and quality of life;
- Slowing the growth of health care costs, which slows the cost-shift impacting insured payers; and
- Maintaining the County as an attractive location for high quality employers seeking a productive workforce.

Finding effective solutions to further address the problems of the uninsured is a daunting task. There are many (and often conflicting) ideas and opinions. It will be important for Leon County to keep in mind that the *good* sought in this initiative should not be sacrificed in an attempt to achieve a *perfect* solution to the uninsured problem.

To help further this initiative, the County has engaged Mercer Government Human Services Consulting (Mercer) to:

- Recommend a health care delivery model meeting the needs of the County's residents,
- Review existing clinics currently serving the uninsured,
- Assist in developing a benefit package for this population,

- Estimate the cost of the benefit package, and
- Analyze potential program benefits and costs.

Background

Nationally and locally, in Leon County, the costs of health care have risen to the point that many of the County's employers can no longer afford to provide health insurance benefits for their employees, and many employees can no longer afford to purchase individual health insurance policies. As the number of low-income County residents without health insurance increases, more uninsured residents are seeking health care at the County's two hospital emergency rooms. This results in more uncompensated costs for the two hospitals. Uncompensated care forces providers to charge higher prices to insured payers to cover the uncompensated costs for those who cannot pay.

In an effort to provide enhanced and improved health care services to the uninsured citizens of Leon County and to reverse the trend of ever-increasing uncompensated care, the County is reviewing various options. In addition to providing enhanced and improved health care services, the initiative will help diminish the "cycle of uncompensated care" and the number of uninsured in the County.

Findings

Stakeholder Meetings

To better understand the County's community health care goals and priorities, we met with a variety of stakeholders in the County, and focused on two primary questions:

- What are the components of a successful program design for a health care delivery model in the County?
- What are the barriers to a successful health care product for the uninsured in the County?

Resoundingly, stakeholders desire to have continued community involvement in providing health care services to the County's uninsured. While universal agreement on continued community involvement exists, there are disparate ideas on how best to use community resources to accomplish the task at hand. Ideally, the recommended service delivery model will integrate community resources to the greatest extent possible.

Clinical Review

A review of the clinics currently providing care to the uninsured showed that both Bond Community Health Center, Inc. (Bond) and Neighborhood Health Services, Inc. (NHS) are critical components of the safety net for Leon County. They help to reduce health disparities in the County's most vulnerable populations by providing culturally sensitive, high quality primary health services and resource support. Unfortunately, the demand for

services is greater than the current provider capacities of the clinics. Both clinics are facing serious threats to their financial stability and viability.

To help alleviate this financial threat, it would be ideal for the clinics to merge under the Bond Federally Qualified Health Center (FQHC) umbrella. Among other advantages, NHS could access better pharmacy prices under 340B pricing, be eligible for federal grants' monies to expand clinical services, and have access to a sound administrative and quality program structure.

Recommendations

- In evaluating the ability of various health benefit arrangements to meet the County goals, Mercer recommends implementing an Administrative Services Only (ASO) model that will:
  - *Have budget stability and predictability.* As the program is being funded by tax dollars, it must remain within the budgeted amount. The product should incorporate built-in mechanisms to help achieve this goal.
  - *Build on existing best practices and preserve the attributes of the existing program.* Any change from the current model design should enhance what is already working well. Specifically, Bond and NHS should be part of the primary care network.
  - *Contain a strong element of county government accountability and control.* Given that the County is accountable to its taxpayers, the County will need to react quickly to emerging issues within the County and report on the quality and cost-effectiveness of the program.
  - *Be brought to the market in a timely manner, requiring minimal start-up or ramp-up time.* Once initial funding is approved, there will likely be expectations of implementing the program in the immediate future.
  - *Avoid "crowd out."* A significant concern is the potential that residents who currently have health care insurance will drop that coverage so they can be covered by the County's program.
  - *Integrate community supports including existing provider participation and county and federal funding.* The interest and dedication of the community in serving this population should continue to be a core component in the County's future health care delivery model.
- Leon County should consider implementing a Three-Share model, which targets the working uninsured (as versus the broader group of the uninsured). It requires cost sharing by the employee, employer and a third payer – in this case Leon County.
- Bond and NHS should be merged. Merging them under the Bond umbrella will provide integrated leadership and management infrastructure, while enhancing the financial component of operations.

- Funding to Bond and NHS should be maintained or increased. They are critical components of the health care safety net and should be funded to enable them to continue in their mission.

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Background

Health Care Plan for Uninsured Leon County Residents

The people of Leon County, along with those in most other parts of the nation, are facing a health care cost crisis. The costs of health care have risen to the point that many of the County's employers can no longer afford to provide health insurance benefits for their employees, and the employees can no longer afford to purchase individual health insurance policies.[1] The result has been a:

- Growth in the number of low income, uninsured residents who seek health care at the County's two hospital emergency rooms, resulting in an increase in the uncompensated costs for the two hospitals[2];
- Growth in private sector insurance costs as the hospitals and other County health care providers are forced to charge higher prices to insured payers to cover the uncompensated costs for those who cannot pay.[1]

Who are the low income, uninsured residents not covered by a publicly funded program? Low income, uninsured residents not eligible for publicly funded programs are primarily the working adults (under age 65) employed by businesses that do not offer health insurance benefits, the self employed, those with part-time jobs not eligible for employee benefits, and the unemployed who are seeking work.

Publicly funded health care programs are limited primarily to Medicare (which covers individuals over the age of 65), Medicaid (which primarily covers low income individuals with severe disabilities and low income pregnant women), and KidCare programs (which cover children from low income, uninsured families). While it is difficult to estimate the

[1] Primary Healthcare Implementation Advisory Board: "Comprehensive Health Care Report" (January 2006).

[2] Agency for Health Care Administration: Florida Hospital Uniform Reporting System, FY 2000, 2001, 2002, 2003 and 2004.

exact number of uninsured residents in Leon County, we estimate there are likely to be between 22,300 (10% of population) and 31,000 (14% of population).

Health insurance in Florida is a complex issue, affected by a wide range of factors, including economic fluctuations and cultural traditions, including the following[3]:

- More than a third of young working-aged adults (ages 19 to 24) are without coverage.[4] Some of this is due to their decision to decline coverage. But it is also due to being on the unfavorable side of two-tier wage agreements, or the fact that many young workers are forced to take entry-level positions without benefits (as temporary workers, substitute teachers, or contract hires).
- There are many reasons that those born outside the U.S. are at greatest risk of uninsurance. Most recent immigrants do not qualify for government-sponsored programs, and the service jobs available to immigrants are the least likely to offer health coverage through the workplace.
- The significant decrease in uninsurance among preschoolers and slight decline in uninsurance among older children is attributable to effectiveness of the State's children's programs. These programs make publicly supported coverage available to children in working families of low and modest income through Medicaid and related programs.

Current Health Care Environment

The current health care environment in Leon County, and in the State as a whole, is experiencing escalating costs of health insurance, forcing businesses to cease providing health insurance benefits for their employees.

- The primary method by which most individuals acquire health insurance is through their employer's employee group insurance benefit programs (91% of insured). Only 9% of the people with health insurance buy their insurance as individual policies. Thus, the ability of businesses to offer health insurance benefits to their employees is critical to maintaining an insured population.
- A 2002 survey of Florida businesses by the Florida Chamber of Commerce found that:
  - Only 76% of Florida employers offered health insurance benefits to their employees. Based on prior Chamber surveys, the 76% rate of employers is down from 77% in 2001, 86% in 2000, and 91% in 1999.
  - 55% of employers who were unable to offer health insurance benefits cited high costs or limited access to group health insurance as the reason.
  - 42% of the employers indicated that they will be forced to consider eliminating health insurance benefits if they experience further increases in premiums.

[3] "The Florida Health Insurance Study" (November 2004).

[4] Duncan, et al., "The Florida Health Insurance Study 2000" (Updated 2004, January 2000 & 2004).

- National research indicates that for each 1.0% increase in health insurance costs, 0.084% of the population lose their health insurance.[5] Applying this ratio to Leon County indicates that the 13.9% increase in insurance costs in 2005 alone may have resulted in an estimated 2,452 County residents losing their health insurance.
- Small businesses are especially vulnerable to increases in health insurance costs because of the size of their employee groups and their generally lower profitability. Since 94.8% of the County's businesses are small businesses (with fewer than 50 employees), Leon County's insured employees are at risk of losing their health insurance.
- Uncompensated care results from the uninsured population seeking medical care and being unable to fully pay for these services. In recent years, the uncompensated costs passed on, primarily, to insurance payers was over $20 million annually.[6] This amount represents an "invisible tax" that is charged on insurance policies to cover the uncompensated costs of treating low income, uninsured patients. The cost of the "invisible tax" is currently approximately $97 per insured person per year.[7]

Situation to Become Worse

Despite having the lowest uninsured rate in the State, a cycle has been set in motion in Leon County. Increased costs of health insurance premiums lead to more uninsured residents, which leads to higher uncompensated costs ("invisible taxes"), which leads to more uninsured residents, which leads to higher insurance premiums; and the cycle continues to worsen. Without corrective action to break the cycle:

- The estimated number of uninsured residents in Leon County will grow; and
- The estimated annual uncompensated cost ("invisible tax") of medical care will grow.

Current Health Care Delivery System for Low Income, Uninsured Residents[8]

CareNet, a public and private sector partnership of voluntary health care providers, currently provides primary and specialty health care services to low income and uninsured citizens of Leon County.

[5] Agency for Health Care Administration: "The Uninsured Issue." August 11, 2003 presentation Medicaid/deputy secretary; presentations/uninsured issue 081103.pdf.

[6] The amount of uncompensated care by both Leon County hospitals is the amount of uncompensated care defined by the Florida Hospital Uniform Reporting System (FHURS) as *Charity Care*. What is referred to by the local press as *Hospital Uncompensated Care* is actually Charity Care and Bad Debts, which for Leon County hospitals was $84 million in FY 2004-2005.

[7] Primary Healthcare Implementation Advisory Board: "Comprehensive Health Care for the Uninsured" (January 2006).

[8] Primary Healthcare Implementation Advisory Board: Annual Report Fiscal Year 2004-2005, "The Leon County Primary Healthcare Program."

CareNet's goals and objectives include:

- Providing access to primary and specialty health care services in the most cost effective and efficient manner;
- Leveraging County, State, federal and private funds to the highest extent possible;
- Establishing continuity of primary care relationships and reducing non-emergent hospital emergency room visits by Leon County residents; and
- Maintaining high regard and respect for individual dignity.

CareNet providers provide an array of services, including primary care, specialty physician care, prescription drug services, and hospital uncompensated medical care.

Primary Care

Bond and NHS provide primary care; both clinics provide a wide range of primary health care services for children and adults. The clinics accept patients by appointment or walk-in and upon referral from hospital emergency departments. Bond and NHS provide social workers and case managers for patient follow-up. Both clinics offer extended hours of operation for medical service delivery and are well situated to public transportation.

Clinic facilities offer onsite laboratory services and on-site care and case management for patients with diabetes and hypertension.

Specialty Physician Care

Significant to the CareNet model of health care service delivery is the We Care Network of the Capital Medical Society Foundation. Currently, availability of specialty care is limited by the capacity of various volunteer specialists who donate their assistance to provide these services.

Prescription Drug Services

The Florida A&M University (FAMU) College of Pharmacy and Pharmaceutical Sciences provides prescription drug services at Bond. Pharmacy services are supported by FAMU. Prescription drug cost is substantially reduced by the participation of the FAMU pharmacy in the federal prescription drug purchasing program. The pharmacy programs also provide the opportunity to take advantage of the drug manufacturers special low-income and uninsured programs.

Hospital Uncompensated Medical Care

Capital Regional Medical Center and Tallahassee Memorial HealthCare provide inpatient care for referrals from the We Care Network. Historically, the inpatient hospital services have been provided without charge.

Problems with the Current Health Care Delivery System for Low Income, Uninsured Residents

Bond and NHS, currently providing a medical home for some uninsured residents of Leon County, do not have enough resources to meet the needs of this group. Bond sees approximately 5,000 uninsured annually, while NHS serves approximately 2,800. For those uninsured residents without a medical home, health care costs are prohibitively expensive.

In addition, the delivery of care does not adequately entail preventive and consistent treatment. The system can be characterized as an "isolated encounter-based" delivery system in which low income, uninsured patients[9]:

- *Often use the hospital emergency rooms for their medical care needs*. Because emergency rooms are designed, equipped, and staffed to treat major medical emergencies, they are much more expensive places to receive primary care treatments than physician offices. Data from the County's two hospitals show that over 30% of the annual emergency room visits by low income, uninsured patients are not emergencies[10] and could be treated in a physician office at an 82.5% lower cost.[11]
- *Routinely postpone seeking medical treatment until the illness has progressed to a critical level, requiring greatly increased costs of treatment.* This is especially true for patients with chronic diseases such as diabetes, asthma, hypertension, and cancer where early treatment could prevent disease progression, thereby enabling the person to continue working and preventing subsequent hospitalizations and medications.
- *Frequently do not get prescriptions filled or comply with physician follow-up treatments.* Again, such tendencies allow their diseases to progress to the point where much more expensive treatments are required.
- *Often lack the continuity of care that is critical for quality care, leading to treatment inconsistency and greater chances of disease progression.*

Note: Unless otherwise footnoted, this *Background* section is based on information found in "A Report on Comprehensive Healthcare Services for Under and Uninsured Leon County Residents" by the Primary Healthcare Implementation Advisory Board (PHIAB), approved December 8, 2005.

[9] Primary Healthcare Implementation Advisory Board: "Comprehensive Health Care Report" (January 2006). (The following information comes from this study, unless otherwise noted.)

[10] Primary Healthcare Implementation Advisory Board: "FY2004-05 Non Emergency Visits Tallahassee Memorial Hospital and Capital Regional Medical Center Study" (February 2006).

[11] Primary Healthcare Implementation Advisory Board: "Cost Analysis: Physician OV vs. Hospital ER Visit" (August 2002).

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Health Care Delivery Model Development

The primary goal of this study is to analyze and recommend a health care delivery model to cover the currently uninsured in Leon County. This process involves:

- Evaluating existing health plan models in the marketplace,
- Understanding the health plan funding mechanisms and revenue stream alternatives, and
- Defining an affordable benefit set to be administered by the health plan.

In determining which models to evaluate, we reviewed existing models across the country, including those used in uninsured initiatives as well as those previously considered in Leon County. Primary model types include:

- **Clinic Model –** Public monies are either allocated to a clinic to provide as much care as possible to low income individuals or contracted on a per unit basis. Financial risk can be controlled (and shifted to the clinic) if a set budget allocation approach is used. Besides serving uninsured individuals, the clinic may serve Medicare and Medicaid patients, thus providing greater continuity of care as patient eligibility changes and providing a broader financial base for the clinic. The clinic focuses on primary and preventive care. Specialty and hospital care are referred out as needed, but usually are not supported by clinic funds.
- **Health Maintenance Organization (HMO) Model –** Premiums are paid on a per member per month (PMPM) basis to manage the health care program for low income, uninsured residents. The HMO contracts with clinics, physicians, specialists, hospitals and other potential providers, such as dentists. Financially, the County shifts medical claims risk (or variability) to the HMO and typically pays an additional risk premium for this. Collectively, these service networks provide comprehensive care and case management for primary and preventive (as well as urgent and chronic illness) care.

- **Consumer Directed Health Plan (CDHP) Model –** Promotes health care consumerism and emphasizes patient involvement by shifting some of the financial risk to the consumer. While the model itself can be similar in infrastructure, services offered and provider network to an HMO or ASO, it differs in the financial decision making emphasis placed on the consumer. This is accomplished by designing a product which requires the consumer to pay for services until a pre-determined financial threshold is reached. From there, the insurance plan will share in future costs. Additionally, funds are set aside to help pay for these services. For an individual, a CDHP may require over $1,000 to be set aside in a Health Savings Account (HSA), or similar product, to help pay for services.
- **Volunteer Model –** An extensive network of providers willing to volunteer their services is organized to provide charity care throughout the community. Referrals are coordinated to avoid overburdening providers. Primary care and specialty providers may offer services in clinics or private offices. Inpatient costs are covered by area hospitals. Area pharmacies may participate. The cost of health care for low income, uninsured patients is absorbed by providers primarily by charging higher costs to paying patients.
- **ASO Model –** An ASO model administers care in a similar manner as an HMO. A key difference between the two models is who bears the financial risk of the program. In an ASO model, the County would have greater financial risk than with an HMO model, as claims are paid on a per encounter basis in the ASO model.

Variations for each of these models were considered as part of this process. Two of the models were ruled out fairly quickly as they would not be good solutions in the current environment. The Volunteer model was determined to be unsustainable in its current version. In our stakeholder meetings, it was apparent that asking for significantly more provider volunteer time was not feasible and not an effective method to expand the current network. The CDHP model was also dismissed as it is dependent on the ability of the insured to pay for many of the initial services with funds set aside by the insured in a HSA or similar fund. This is not feasible with this population as this type of model will provide too large of a “hurdle” (too large of an initial financial commitment to fund the HSA) and will severely limit access to care.

Uninsured issues are similar across marketplaces; however, the method for addressing these issues varies depending on the values and resources in the given marketplace. Therefore, criteria used to evaluate the remaining three models came primarily from the stakeholder meetings and secondarily from marketplace knowledge. This is further discussed in the *Stakeholder* section of the report.

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Stakeholder Meetings

To better understand the County's community health care goals and priorities, we met with a variety of stakeholders in the County:

- PHIAB Board Members,
- Capital Medical Society,
- Leon County Administrators,
- Capital Health Plan CEO,
- Florida A&M University School of Pharmacy Representative,
- Bond Community Health Center,
- Neighborhood Health Services, and
- Tallahassee Memorial Hospital CEO.

The interviews focused on two primary questions:

- What are the components of a successful program design for a health care delivery model in Leon County?
- What are the barriers to a successful health care product for the uninsured in Leon County?

Resoundingly, stakeholders desire to have continued community involvement in providing health care services to the County's uninsured. Stakeholders also see the benefits of enhanced and improved health care services. While agreement exists on these points, there are disparate ideas on how best to use community resources to accomplish this. Ideally, the recommended service delivery model will integrate community resources to the greatest extent possible.

Other considerations for the health care delivery models, as mentioned in the interviews, are grouped into four main categories:

- **Product design:** Cost, quality and access to services need to be balanced. Given the limited budget, does the County want to provide more services to a few people or fewer services to more people?
- **County oversight:** As part of its accountability to tax payers, the County needs to have management control over the direction of the program (i.e. vendor selection for administering health care services). Additionally, County program goals need to be integrated into the design of the program.
- **Implementation:** To stem the tide of a rising number of uninsured, the agreed upon initiative needs to be implemented as quickly as possible, resulting in accessible health care coverage for the currently uninsured.
- **Integration:** To the greatest extent possible, existing community resources should be leveraged and further integrated into a system of care. The existing CareNet providers in the County should play a significant role in the future delivery of health care.

Other key stakeholder goals, while not universally shared and some with competing interests, are listed and defined as:

Product Design

- **Budget stability:** Optimally, the level of funding should be set and subject to minimal change over the course of the year.
- **Maximize number of eligibles enrolled and treated:** Available resources should be spread to cover as many people as possible.
- **Have access to services:** Factors such as geographic location of residence and the service delivery model design should not limit access to services.
- **Provide platform for quality of care and other initiatives:** Infrastructure is needed to effectively use data and marketplace knowledge to further the care of the uninsured. There needs to be a measurable strong case management component.
- **Have an appropriate benefit level and be financially viable:** The core benefit set will, at a minimum, provide affordable basic health care services.
- **Accountability of program in achieving Leon County goals:** The model should incorporate a tracking and reporting system to measure program experience.

County Oversight

- **Politically sustainable:** The initiative needs to be accepted by the community/providers on a long-term basis to ensure program continuity.
- **Ability to make changes quickly:** The model needs the flexibility to reflect changes as requested by the County, i.e., a change in benefits covered.

- **Taxpayer accountability:** Ultimately, the County taxpayers need to be kept informed of the impact of the initiative and have a say in the various components of the program such as the benefit design and the program funding.

Implementation

- **Ability to bring product to market in a timely manner:** The model needs to have the necessary infrastructure to support expansion of provider capacity, program enrollment and other delivery system components upon commencement of the program.
- **Effective in administering product:** The model should follow guiding principles of the program, such as prescribing use of generic drugs when possible.
- **Ability to operate in a dynamic marketplace:** Flexibility to react to the health care marketplace to incorporate changes in practice patterns and to coordinate care across health care programs is needed.

Integration

- **Gap product (should not compete with existing programs):** This product should fill the current health care gap for the uninsured population with minimal crowd-out of existing health care coverage.
- **Utilize existing programs:** What is currently working well should be maintained and enhanced. For example, FQHCs are eligible for 340B pricing for pharmaceuticals – this feature should be maintained and expanded as possible.
- **Leverage existing resources/funding:** Existing funding sources should not be affected, if at all possible. For example, Bond's FQHC status and federal funding should be maintained.

These themes have been considered and integrated as part of the criteria for comparing health care delivery models, as shown in the matrix on the next page.

A rating system from "low" (one star) to "high" (three stars) reflects the evaluation of each of the models. In summarizing results by each of the four primary areas, each model has its own strengths and weaknesses. A clear-cut choice does not exist for *the* best model. Rather, some modifications to the selected model will be needed to minimize inherent weaknesses to tailor a model to meet the County program needs.

Operational Model	**HMO**	**Clinic**	**ASO**
Entity at Risk	***Vendor***	***Clinic***	***County***
Product Design	☆☆½	☆☆	☆☆
Budget stability			
Maximize number of eligibles enrolled and treated			
Have access to services			
Provide platform for quality of care and other initiatives			
Have an appropriate benefit level and be financially viable			
Accountability of program in achieving Leon County goals			
Leon County Oversight	☆	☆☆	☆☆☆
Politically sustainable			
Ability to make changes quickly			
Taxpayer accountability			
Implementation	☆☆	☆½	☆☆½
Ability to bring product to market in a timely manner			
Effective in administering product			
Ability to operate in a dynamic market place			
Integration	☆½	☆☆☆	☆☆
Gap Product: should not compete with existing programs (Avoid crowd-out)			
Utilize existing programs			
Leverage existing resources/funding			

Low = ☆ Medium = ☆☆ High= ☆☆☆

5

Clinical Evaluation

Overview of the Clinics and the Uninsured

Bond and NHS have been the sole providers of primary health care services to the uninsured and homeless population in Leon County for approximately 25 and 30 years respectively. Both NHS and Bond are free-standing, community-based health centers sharing a long-standing primary mission of providing preventive, medical, social, and health education services primarily to low-income, uninsured, and homeless individuals. Both clinics are located in medically underserved neighborhoods with extensive poverty and unemployment. The majority of their patients live in households with incomes below the 100% poverty level and more than 70% of their combined patient panels are minorities. Bond is located on the south side of Tallahassee, south of the FAMU campus, and NHS is located near the center of the city, north of the capitol complex. Bond is a designated FQHC and, as such, has a much more structured approach to providing and monitoring care services. Both clinics provide services to all patients regardless of their ability to pay. The clinics not only act as a safety-net for vulnerable populations in the community; they also assist with controlling state and county health care expenditures by assisting patients with enrollment into entitlement programs. They also are active sites for clinical education experiences for FAMU pharmacy, nursing, nutrition, and social work students, Florida State University (FSU) medical and nursing students, Tallahassee Community College (TCC) nursing students, Lively Technical for medical assistants and practical nursing students, and Keiser College for medical assistants.

The uninsured in Leon County receiving care at the two clinics appear to be comprised of working families and the homeless.

- **Working families:** Some are self-employed with no insurance and others employed part-time or full-time outside of the home with low and moderate incomes for whom health insurance coverage is not available in the workplace or is unaffordable.
- **The homeless:** Jobless individuals who are primarily living in shelters.

Although both clinics have uninsured clients from both these categories, NHS appears to have more homeless clients as a proportion of its total patient panel than Bond because of its closer proximity to the homeless shelters and because very few of its patients have entitlement insurance such as Medicaid or Medicare. NHS estimates that approximately 25% of the people in the downtown homeless shelters receive continuing primary care from them. Because Bond has a van that can transport scheduled patients, it appears to have a wider service area than does NHS.

Typically, in an insured population, primary health care is the first point of contact with the health care system. In the uninsured population nationwide, often the emergency room is not only the first point, but it is also a continuing primary source of contact as very little follow-up care is available. Both Bond and NHS are providing health care services to the community as a source of primary care and frequently, as a center for follow-up care for uninsured patients seeking emergency care first. A continuing strategy of both clinics has been to outreach to the community to attempt to market their services to citizens of Leon County to promote their preventive health initiatives and primary care services and to assist in stemming the tide of unnecessary utilization of emergency services. They both work closely with hospital emergency diversion programs in Tallahassee to provide follow-up care for patients who do not have a primary care provider (PCP). They seem to be being adversely affected in these referrals as most of the patients referred to them by the hospitals are uninsured. Clinic staff sense that emergency patients with Medicaid and Medicare who are without a designated primary care physician are being referred to the primary care clinic at Tallahassee Memorial Hospital. The primary care clinic serves the indignant population and is staffed, in part, by medical students in the residency program. Both Bond and NHS staff would like to see additional referrals of patients with Medicaid, Medicare, and third-party coverage to assist with overall financing of health service delivery. Both clinics believe they are perceived by the community as clinics only for the poor. They would like to change their image to be more all encompassing of the community as a whole and include more patients with alternative payer sources, while continuing their missions of providing care to the uninsured and to those with low-incomes.

Framework for the Clinic Evaluation

Research has shown that on a national basis a lack of health care insurance compromises people's health as they are more likely not to receive preventive care, are more likely to be hospitalized for avoidable health problems, and are more likely to be diagnosed in the late stages of disease.[12] To determine the effectiveness of health care delivery to the uninsured in Leon County, Mercer's evaluation of the care being delivered by the clinics was reviewed within a continuity of care framework. For the purposes of this review, continuity of care is defined as "the extent to which health care services over time are perceived as a coherent and connected succession of events consistent with a patient's

[12] Kaiser Commission on Medicaid and the Uninsured: "The Uninsured: A Primer: Key Facts about Americans without Health Insurance" (January 2006).

medical needs and personal context."[13] Continuity in health care, generally, is perceived to be a result of a combination of adequate access to care, effective communication between providers and receivers of care, a balance of patient self-management with provider management of care, and appropriate coordination of care among providers, organizations, and community resources.

Using the continuity framework, an evaluation of the two clinics was conducted over a four day period from February 28 to March 3, 2006. The purpose of the clinic evaluation was to determine the scope, breadth, and depth of the health care services currently being provided to uninsured patients in clinic settings in Leon County. Strengths and areas of opportunity were identified to assist in quantifying viable approaches for potentially expanding health care services to the uninsured population in the future.

The clinical evaluation consisted of two phases. The first phase was designed to obtain specific clinic information prior to conducting an on-site review. The information request document was sent to the clinics to provide specificities regarding:

- Staffing,
- Services,
- Space,
- Hours of operation,
- Types/scheduling of appointments,
- Medical record systems, and
- Quality improvement processes.

The second phase consisted of a two day on-site visit at each clinic. This component of the clinical evaluation consisted of a review of six major areas:

- Staffing, facility structure and basic management/operational processes;
- Promotion of clinical care that is consistent with scientific evidence;
- Organization of patient and population data to facilitate efficient and effective care;
- Provision of patient self-management support and empowerment of patients;
- Creation of a culture, organization, and mechanisms that promote safe, high quality care; and
- Utilization of community resources to meet patient needs.

[13] Centre for Health Services and Policy Research: "Big Steps, Small Leaps: Defining and Measuring Continuity of Care." University of British Columbia, Vancouver. (November 2004).

In reviewing these six areas, a number of processes were conducted including, but not limited to:

- A tour of the facilities;
- An observation of clinic functions including use of space;
- Interviews with management, providers and staff;
- Reviews of strategic plans, goals, policies and procedures, and care provider job descriptions;
- Reviews of scheduling processes and review of actual schedules for the past two months for both staff and patients;
- Review of patient education materials, community resource manuals; and
- A medical record review to identify consistency and continuity of care being provided to the uninsured population.

The detailed findings of the review are summarized in the table at the end of this section. The overall findings – major strengths and areas of opportunity – identified in the clinic review are summarized on the following pages. After this summary, the recommendations for future support to meet the need to decrease health disparities of the vulnerable populations of Leon County are presented.

Findings

Major findings of both Bond and NHS are identified in the following table. The letter 'S' identifies the finding as a strength of the organization and a letter 'O' identifies the finding as an area providing opportunity for improvement.

CATEGORY	Bond	NHS
Facility and Administrative Structure		
Board of Directors and the clinic's administration are involved in identifying and addressing the adapting health care needs of the community they serve while trying to determine how they can remain financially viable with limited resources	**S**	**S**
Has FQHC status and as such reflects strong leadership and managerial infrastructure	**S**	**O**
Has strong Medical Directors and competent, caring health care professionals	**S**	**S**
Has long-term experience in delivering health care to the indigent population	**S**	**S**
Receives 340B pharmacy pricing	**S**	**O**
Has adequate space and an attractive facility site in which to provide care	**O**	**O**
Actively pursues grant opportunities to allow for an increase in capital	**S**	**O**
Staffing patterns are efficient	**O**	**S**
Has sufficient employed professional staff to provide consistent clinical care	**S**	**O**

CATEGORY	Bond	NHS
Promotion of Clinical Care		
Delivers accessible, affordable, comprehensive, quality primary health care services in a culturally competent manner	**S**	**S**
Has Diabetes and HIV/AIDS collaborative programs	**S**	**O**
Has adequate clinic services in caring for pediatric patients	**S**	**O**
Has adequate clinic services in the obstetrics, gynecology and mental health areas	**O**	**O**
Organization of Patient Information		
Has organized medical records and a tracking mechanism	**S**	**O**
Physicians are able to communicate electronically through an e-health website with their patients who have access to computers	**S**	**O**
Has an electronic medical record system	**O**	**O**
Provision of Patient Self-Management Support and Empowerment of Patients		
Has specific risk assessment tools for most major disease categories	**O**	**O**
Provides care management services to assist in coordination of care	**S**	**O**
Creation of a Culture, Organization and Mechanisms that Promote Safe, High Quality Care		
Has an excellent quality improvement program with defined performance measures and a structured monitoring system	**S**	**O**
Has dedicated case managers for disease collaborative programs and for women's health	**S**	**O**
Ensures prompt receipt of ER and hospital discharge records and specialty consultations, and consistently places them in patients' medical records to ensure coordination of care activities	**O**	**S**
Mobilization of Community Resources to Meet Patient Needs		
Has vital connections with the community and are actively involved in outreach activities	**S**	**S**
Collaborate with CareNet and the We Care Networks by making timely patient referrals to specialty health care providers, and then, continue to coordinate follow-up and primary care for these patients	**S**	**S**
Is a referral base for Leon County Health Department for mammograms, Medicaid eligibility screening, Women Infant Children's (WIC) program, immunizations, and medications for Sexually Transmitted Diseases (STDs)	**S**	**S**
Has educational affiliations and provides clinical opportunities with students in the College of Medicine and Nursing at FSU, the Colleges of Pharmacy, Nursing, and Social Work at FAMU, the College of Nursing at TCC, Medical Assistants from Keiser College, and Medical Assistants and Practical Nursing students from Lively Technical	**S**	**S**
Actively collaborates with pharmacy assistance programs to enable patients to receive thousands of dollars worth of free prescriptions	**S**	**S**

CATEGORY	Bond	NHS
Mobilization of Community Resources to Meet Patient Needs, Continued		
Actively collaborates with a variety of social service community agencies and disease-specific support groups to provide additional resources for their patients	**S**	**S**
Value and use the contributions of community volunteers and keep the spirit of 'volunteerism' alive within the medical and educational systems in Leon County	**S**	**S**

Recommendations

The clinics have been providing comprehensive, culturally competent, health care and an array of critical social and financial assistance services for their patients without regard for payment to the uninsured and low-income for decades. Major recommendations pertaining to funding needs at both clinics follow.

Facility and Administrative Structure

- An ideal situation would be for the clinics to merge under the Bond FQHC umbrella to provide the leadership, management infrastructure, quality program, and financial support that organizations under Section 330 of the Public Health Service Act as amended by the Health Centers Consolidation Act of 1996 (P.L. 104-299) receive, including access to grants, increased payment for services, and 340B pharmacy pricing.
- Both clinics need facility renovations to enhance their use of space to provide efficient health care services.

Promotion of Clinical Care

The clinics need assistance with additional funding to provide care for the uninsured population. One mechanism to do this is through health insurance for working adults who are currently uninsured. Additional revenues can assist the clinics in hiring physicians and nurse practitioners to care for an expanded patient panel. Furthermore, patient care can be improved and enhanced if additional funds are dedicated to providing more services, both for the clinics and for other providers in the network.

Organization of Patient Information

Both clinics are in need of financial assistance to establish an electronic medical record system to manage the complexity and volume of information required in providing and monitoring complex, coordinated care.

Provision of Patient Self-Management Support and Empowerment of Patients

Both clinics could use additional funds to expand their use of case management services for all major complex disease categories within their patient panels.

Creation of a Culture, Organization and Mechanisms that Promote Safe, High Quality Care

NHS needs to develop a quality improvement program with defined performance measures and a structured monitoring system. Bond needs to routinely acquire specialty consultation, emergency department, and hospital discharge summaries to ensure coordination of care.

Mobilization of Community Resources to Meet Patient Needs

Both clinics need contracts with additional third party payers to enhance their image as a quality provider of care to all patients, not just the poor. Medicaid referrals for care are needed also as the reimbursement is an important component in keeping FQHC's financially stable.

Advantages of Merging Bond and NHS

Having one large modern health center managed by Bond under the FQHC umbrella could potentially:

- Expand health care access by co-locating services and staff at one location;
- Enhance and improve administrative, staffing, facility, and equipment efficiencies;
- Enlarge the patient base and target populations;
- Allow for expansion of preventive, primary, and specialty health care services;
- Provide an excellent medical/nursing/pharmaceutical educational site with sufficient space, modern equipment, and electronic medical records;
- Broaden recognition and acceptance of patients regardless of their insurance status or their ability to pay;
- Broaden the pool of players in collaborating in a consolidation of limited health care funding dollars;
- Assist in obtaining entry into health plans and networks;
- Allow continuance of a strong relationship with HRSA Bureau of Primary Health Care (HRSA/BPHC) and continuation of existing federal grant monies with the opportunity to expand the grants;
- Increase sources and access to capital, financial support, and other resources; and
- Ensure the survival of a strong, existing FQHC which has extensive experience in providing care to underserved populations.

Summary

Both community health centers are critical components of the safety-net for Leon County in helping to reduce health disparities in its most vulnerable populations by providing culturally sensitive, high quality primary health services and resource support. Although

these clinics have not been able to stop the flood of unmet health care needs of the indigent population, this should not be viewed as a failure of the clinics to respond to the needs of the community to provide quality, timely care; but rather, the reality is that the need for services is far greater than the current capacities of the clinics to provide.

While both health centers are providing affordable, accessible, quality health care by professional, dedicated staff, only one, Bond, has a strong administrative leadership component. Bond operates under the rigorous performance and accountability requirements expected of health centers in the FQHC system. These include administrative, clinical and financial operational requirements.

Expansion of covered services is greatly needed; there is an argument for richer benefits. A definite need exists to enhance services, including:

- Inpatient hospital care,
- Preventive services – such as mammograms for younger women (under age 45), flu shots, etc.,
- Specialty services (as volunteer services are limited),
- Lab services, and
- Radiology services.

Providing these services will improve the health status of this population.

Clinical Evaluation Review Table

Category	Bond	NHS	Comments
Facility and Administrative Structure			
Facility space	Operates from two locations in close proximity to each other. The buildings are designated by their addresses: 710 and 872. One building is in a renovated market location and is leased from FAMU. The other building is a newer, more modern facility provided by the Leon County Commissions. Between the two buildings there are approximately 10,000 square feet, 15 examination rooms, 4 blood drawing stations, and a pharmacy. There are no procedure rooms. Neither building was originally designed for primarily delivering patient care services so the traffic flow for care delivery purposes is not ideal.	Operates in a former school building, the Lincoln Neighborhood Center, which is a community services building housing additional offices such as a day care, police station, and community diabetes program. The space utilized by the clinic is approximately 4,700 square feet and has 7 examination rooms, 1 small blood drawing area, and a pharmacy area. There are no procedure rooms, although one office area has ophthalmology equipment in it and vision testing is conducted by a volunteer optometrist one day a week.	Neither clinic has optimal facility design conditions for delivering efficient patient care services. ▪ Bond's site is in need of renovation. The interior is clean, well-kept, but very crowded. Between the two buildings, there is adequate space to provide care for the number of patients currently being seen. However, providing services in two different buildings is not efficient in terms of staffing, medical record storage and accessibility, equipment usage, lab and sterilization processes, and access to the pharmacy. There is inadequate space for staff meetings or breaks. ▪ NHS's space could be improved. The patient waiting area is divided into two different separately enclosed small areas which are divided by a long wide hallway. The examination rooms are small. The pharmacy is not in a secured area and storage of medication and supplies is haphazard. The facility has an inadequate phone system, as well as old and outdated computers, fax machines, and copiers. There are only two toilet areas which are inadequate restroom space for the volume of clientele and staff. The lab and sterilization areas are open and easily accessible to patients and/or their families. There is inadequate space for medical record storage and archiving. There is inadequate space for staff meetings or breaks.

Category	Bond	NHS	Comments
Facility and Administrative Structure, Continued			
Services	Provides preventive care services as well as medical and health education services for acute and chronic conditions. Provides primarily pediatrics, adolescent, and OB/GYN services in one building and adult services in the other building. Has grant funded Diabetes and HIV/AIDS health collaborative programs as part of a nationwide initiative to address health disparities among the vulnerable populations. Has an HIV Specialist who is responsible for the HIV/AIDS care program. Has part-time ophthalmology services. Actively refers patients to specialty care as needed. FAMU operates the clinic pharmacy. It provides a full-time pharmacist. Medications are procured through 340B pricing, patient assistance programs, and free pharmaceutical samples.	Provides preventive care services as well as medical and health education services for acute and chronic conditions primarily to adults. Occasionally, provides care to children, but not routinely. Volunteer specialists also provide limited (approximately once a month to once every other month) gynecology, orthopedics, mental health, cardiology, dermatology, endocrinology, and eye care. Actively refers patients to specialty care as needed. The pharmacy has been operated by NHS through the use of a part-time pharmacist and a volunteer pharmacist. The pharmacy purchases some drugs at negotiated rates, but does not have the advantage of 340B pricing. It also procures drugs for clients through patient assistance programs and free samples. As of March 1, FAMU began operating the pharmacy.	At both clinics, scheduled appointments seem evenly divided between follow-up of chronic disease conditions and treatment of acute conditions. There are occasional preventive health services visits scheduled. The walk-ins are primarily for initial treatment of acute conditions or for acute exacerbations of chronic conditions. Opportunity exists for preventive health services expansion at both clinics. Mental health services are sorely needed by both clinics. The current available services whether provided at the clinic (NHS) or through referrals (Bond) are inadequate to meet the needs of the vulnerable population. At Bond, most of the OB patients in the past were seen by Registered Nurse Midwives and Family Practitioners. As delivery approached, the patients were referred to outside obstetricians. Recently, an obstetrician was employed to see patients one day a week and to provide delivery services. The clinic administration desires to establish a full-service obstetrics program on a full-time basis, but needs to procure and retain additional clientele with Medicaid or third party coverage to get an adequate-sized patient panel and to help finance the service costs. Currently, Bond refers pregnant women it sees for eligibility for Medicaid programs, but once enrolled, these patients often are not returned to Bond. Instead, they are referred to providers who operate on a more full-time basis. This presents a ‘Catch-22’ situation that Bond is finding difficult to overcome.

Category	Bond	NHS	Comments
Facility and Administrative Structure, Continued			
Strategic plan and goals	Has a detailed strategic plan with targeted goals and activities through February 2007. The plan includes goals, key action steps, measurement criteria, and an evaluation of progress/outcomes.	Has a copy of draft, potential goal statements developed at a Board Retreat during January, 2005, but they were not finalized on the document reviewed. Did identify some goals for 2006 recently in a grant proposal.	Bond, as a FQHC, has specific requirements for strategic planning, administrative management processes, and for the development of clinic specific policies. The clinic appears well managed. NHS' Director was hired only five months ago and prior to that there was an extended period of time that this position was not filled. Administratively, there is a lot of structural work that needs done.
Patient visits	In 2005, had 8,356 patients with 22,729 visits last year. Approximately 72% (6,016) of the patients are uninsured, 13% have Medicaid, and 12.5% have Medicare.	In 2005, had nearly 3,000 patients with more than 8,000 patient visits last year. Approximately 95% of the patients are uninsured and 5% have Medicaid. They have no Medicare patients.	On a national basis in 2004, 40% of health center patients lacked insurance and another 36% were covered by Medicaid. Health centers typically rely heavily on Medicaid to help finance their operations. (Kaiser Commission on Medicaid and the Uninsured: "Health Centers Reauthorization: An Overview of Achievements and Challenges," March 2006.) Both these clinics are supporting a disproportionate share of uninsured versus entitlement covered patients. This places a tremendous strain on their financial situation.

Category	Bond	NHS	Comments
Facility and Administrative Structure, Continued			
Clinic visits/ Access/ Scheduling	Has a total of approximately 53 hours of appointment availability each week. Has evening hours four days a week and is open on Saturdays for five hours. Has open access scheduling allowing for appointments and walk-ins. The vast majority of the visits are single patient visits, but they do have group follow-up/education visits available for patients with diabetes. Has collaborated with FSU Center for Civic Education and Service to provide online communication/consultation between Bond providers and their patients.	Open Monday through Fridays for a total of 59 hours a week. Has evening hours five days a week. No appointments are scheduled on Saturdays as the building is closed. Would like to be open as they believe there is a community need for health care services on the weekends to assist in decreasing unnecessary emergency room visits. Has open access scheduling allowing for appointments and walk-ins. Does not have group visits.	The scheduling of routine appointments has a two to three week wait period at both clinics, unless the provider specifies a return visit sooner which is accommodated. Both clinics see approximately ten or more walk-ins a day. Staffing schedules leave availability to allow for these walk-ins. Both clinics see patients referred from local hospital ER diversion programs for follow-up either on a scheduled or walk-in basis. Since most ERs recommend that patients be seen within 48-72 hours of discharge, the clinics usually accommodate these patients as walk-ins. The extended hours offer patients who work and walk-ins opportunity for convenient access to medical care.
Staffing	Patient care is provided primarily by employed staff – physicians, advanced registered nurse practitioners (ARNPs), a physician's assistant (PA), and LPNs; although there are a few volunteer physicians and ARNPs. **Total staff: 44.84 FTEs**	Patient care is provided 45 hours a week by employed staff – primarily one physician, ARNP, and two LPNs; and approximately 14 hours a week by volunteer professionals. NHS has very limited staffing. **Total staff: 11.3 FTEs**	Bond has a large number of staff; some of it is because of grant obligations; some of it is due to staffing inefficiencies created by working in separate buildings. There is one physician vacancy. FQHCs require a physician to patient ratio of 1:1,500 and a midlevel practitioner to patient ratio of 1:750. A 2004 federal report estimated the medical team productivity was at about 82% which was slightly higher than Florida's FQHC rate and significantly higher than the National FQHC rate. This rate only relates to physicians and mid-level providers. So, there are definitely not too many providers.

Category	Bond	NHS	Comments
Facility and Administrative Structure, Continued			
Staffing, Continued	**Employed staffing includes:** – 2.9 Physicians – 4.01 ARNPs, – 0.8 PAs, – 5.5 LPNs – 7 Medical Assistants (MAs), – 1.0 CEO, – 1.0 COO, – 0.5 CFO, – 1.0 Accountant, – 1.0 Women's Health Coordinator, – 1.0 Front Desk Supervisor/Collections, – 0.63 Reimbursement Specialist, – 1.0 Referral Technician, – 3.5 Medical Records, – 4.0 Receptionists, – 1.0 Community Liaison, – 1.0 Research Interviewer, – 1.0 Social Worker, – 1.0 OB Case Manager, – 1.0 Phone Operator, – 1.0 HIV Case Manager, – 1.0 Transportation Driver, – 1.0 Data Entry, and – 1.0 Maintenance Technician.	**Employed staffing includes:** – 1.0 Physician, – 1.0 ARNP, – 2.0 MAs, – 1.0 CEO, – 1.0 Office Manager, – 0.5 CFO, – 1.0 Exec. Assistant, – 3.0 Front Desk/Intake Specialists, and – 0.8 Social Workers. – The rest of the care is provided by volunteer professionals. Also, non-clinical volunteers help out any where they can.	It should also be noted that FQHCs nationally have higher staffing ratios than "regular" physicians' offices as FQHCs provide more comprehensive care including case management services and defined and extensive quality improvement programs. The excesses in Bond staffing appear to possibly be in the support categories. Given nine providers, the reviewer estimates that support staff (LPNs and MAs) for these providers should be approximately nine (one per provider). Bond has 12.5. The front desk/telephone operator /reimbursement specialists/referral technician positions appear like they could be combined to decrease positions from 7.63 to 5. Medical Records/Data Entry of 4.5 might be reduced to 3. So, a total of approximately 7.63 positions may be able to be reduced if care was being provided in one building. NHS needs additional funding to properly staff their facility. They need an additional physician and ARNP, a Medical Records person, a Case Manager or additional Social Worker at a minimum.

Category	Bond	NHS	Comments
Facility and Administrative Structure, Continued			
Policies and procedures	Had up-to-date detailed, employee, administrative, and clinical policies and procedures specific to Bond activities.	Policies were strictly employee related, general, and had no indications that they had been reviewed or revised in years. None of the policies provided for the review were specifically related to clinic functions.	Policies and procedures defining operations at NHS need to be developed and formalized.
Job descriptions	Had up-to-date job descriptions for every position at the clinic.	Had job descriptions for most positions, but these were old and had no indications.	Job descriptions need to developed or updated for every position.
Promotion of Clinical Care			
Use of evidence-based clinical guidelines	Had organized, up-to-date, evidence-based clinical guidelines for numerous conditions. Many of these guidelines have performance measures associated with them and active monitoring is taking place.	There were no 'official' clinic guidelines; however, the medical director and the ARNP collaborate on keeping up-dated with current, national clinical guidelines. The medical records did indicate that care was consistently being provided according to national guideline standards.	NHS needs to formalize their clinic guidelines to ensure consistency among all providers, especially the volunteers.

Category	Bond	NHS	Comments
Promotion of Clinical Care, Continued			
Documentation tools	Had well-designed disease specific flow-sheets for pregnancy, diabetes, and HIV/AIDS. Does not have a consistent method of screening patients for depression.	Did not demonstrate the use of any flow sheets. Did have a patient assessment sheet that included depression screening.	Regular use of disease-specific flow sheets have been identified in the literature as improving the consistency with which care is provided among both individual patients and population groups. Well-designed forms allow for the tracking of clinical indicators over time. Depression is often a co-morbid condition with both acute and chronic illnesses. The presence of untreated depression tends to increase health care utilization and costs.
Self-monitoring mechanisms	Has a nicely organized, structured quality improvement program with defined performance measures and monitoring mechanisms. Activities of the quality program are reported to a quality committee chaired by the Medical Director. Actions are taken when issues arise.	There is no quality improvement or monitoring program.	NHS needs a Quality Improvement Program to measure patient health outcomes, determine provider accountability, facilitate and support clinical decisions, empower patients, and provide evidence of ineffective practices.
Contact for preventive health reminders or follow-up of care	Medical record documentation did indicate occasional calls/ reminders for preventive health purposes. Follow-up appointments for care of acute and chronic illnesses were consistently documented.	Medical record documentation showed consistent use of calls/reminders for scheduling of preventive health visits. Follow-up appointments for care of acute and chronic illnesses were consistently documented.	Follow-up appointments were scheduled frequently at both clinics especially for patients with chronic illnesses. The frequency seemed very appropriate for the population being served. Close monitoring to ensure that patients understood their conditions, treatment, and medications was documented. Continuous medication management and manual monitoring of lab or diagnostic test results was evident.

Category	Bond	NHS	Comments
Organization of Patient Information			
Medical record system	Uses hard copy medical records. Medical records area is locked and not accessible to patients. Staff has formal processes for securing and tracking records.	Used hard copy medical records. Medical records area is locked and not accessible to patients, but it is located directly behind the reception desk making the area very crowded. An inordinate amount of time is spent searching for medical records as the system is disorganized and there is no tracking of records when they are pulled.	The quality of administrative and medical decisions made in health centers is critically dependent on the availability of accurate, accessible, relevant, current information. Health centers must have systems in place to accurately document the application of health services, as well as have the ability to collect, organize and report the data for internal monitoring, quality improvement, and for future strategic planning purposes. Both clinics are at a disadvantage with their manual medical records systems. However, Bond's system is much more organized than NHS. Bond spends considerable staffing hours manually extracting data from medical records for quality monitoring purposes. Efficiencies could be gained if the records were electronic.
Use of any disease specific registries, tickler systems	Because of their diabetes and HIV/AIDS collaborative projects, there are registries available for these diseases.	Has no disease registries.	Disease registries identify patients by condition and are useful in tracking health outcomes, monitoring screening and follow-up activity, and sending reminders and health information materials to patients.

Category	Bond	NHS	Comments
Organization of Patient Information, Continued			
Evidence of receipt of hospital or emergency department discharge summaries, radiological and diagnostic tests	Review of medical records demonstrated inconsistent receipt of ER and hospital discharge summaries. They did show evidence of timely receipt of pertinent lab and diagnostic testing.	Review of medical records demonstrated very consistent receipt of ER and hospital discharge summaries and pertinent lab and diagnostic testing.	Bond needs to pursue copies of ER and hospital discharge summaries to ensure coordination of follow-up care.
Recall/tickler systems for patient follow-up care or scheduling of appointments after ED and hospital visits or no-shows	Did not demonstrate use of a recall/tickler system on a consistent basis. Did proactively schedule patients for follow-up visits when documented by provider.	Did not demonstrate use of a recall/tickler system on a consistent basis. Did proactively schedule patients for follow-up visits when documented by provider.	A recall/tickler system is useful particularly for preventive health or chronic illness care follow-up to ensure that patients are receiving screenings or necessary lab and diagnostic tests in a timely manner. An electronic medical record system has such a feature.
Provision of Patient Self-Management Support and Empowerment of Patients			
Use of any disease specific risk assessment tools used by physicians or patients	Had risk assessment tools for HIV/AIDS, Lead Poisoning, and a general one for their patient health history.	Had a risk assessment tool for their patient health history.	Both clinics could benefit from the development of additional disease specific patient risk assessment tools.

Category	Bond	NHS	Comments
Provision of Patient Self-Management Support and Empowerment of Patients, Continued			
Culturally sensitive informational materials to transmit guideline information to patients	Has a plethora of culturally sensitive educational materials relating to a variety of acute and chronic conditions that are easily accessible to patients. Culturally sensitive health education posters are also displayed throughout the clinic.	Has some culturally sensitive educational materials, but none are on display or readily accessible to patients.	Documentation in both clinics' medical records indicated the use of educational information being shared with patients by providers.
Provision of coordination with any care management or psychosocial supports in caring for the complex patient	Had a more coordinated approach to care management and referrals to psychosocial supports especially in relation to their disease collaborative programs.	Did not have any care management activities. Was actively involved in referrals to psychosocial supports.	Bond had dedicated case managers for their disease collaborative programs and for women's health.
Documentation of discussions about Advance Directives and copies in medical records	No documented evidence of discussions about Advance Directives was identified and no copies were in charts reviewed.	No documented evidence of discussions about Advance Directives was identified and no copies were in charts reviewed.	Discussions of Advance Directives needs to be conducted and documented in the medical record, particularly as it is a patient's right under entitlement programs. As both clinics expand their patient base to include more members with Medicaid and Medicare, this becomes increasingly important.
Constructive use of patient appointment waiting time	No evidence of constructive use of waiting time.	During initial appointments, patients were asked to fill out a self-risk assessment. For continuing appointments, no constructive use was made for waiting patients.	The patient waiting time can be used for self-risk assessments, self-documentation of health or unhealthy behaviors since last visit, and for reading or viewing health education materials.

Category	Bond	NHS	Comments
Provision of Patient Self-Management Support and Empowerment of Patients, Continued			
Use of any patient physician partnership agreements for patients having difficulty with compliance	Had a contract for patients who were having difficulty with compliance especially related to drug seeking behaviors.	Had a contract for patients who were having difficulty with compliance especially related to drug seeking behaviors.	Evidence was demonstrated by both clinics that the physicians actively use the partnership agreements, both formally and informally. Definite limit setting activities were evident in the record to decrease use of any unnecessary medications which may be addictive.
Use of any patient satisfaction surveys	Did conduct minimal patient satisfaction surveys annually. Documentation showed a response of 10 patients.	Did conduct minimal patient satisfaction surveys annually. Surveys were available in the waiting room, but rarely filled out.	Use of a more robust systematic patient survey process throughout the year could be used by both clinics. They need to actively seek feedback on every visit from their patients.
Creation of a Culture, Organization, and Mechanisms that Promote Safe, High Quality Care			
System for monitoring complaints/grievances, errors, and any quality of care concerns	The quality improvement program provided for a system of monitoring complaints and quality of care concerns.	There was no organized system for monitoring of complaints or quality of care concerns.	NHS would benefit from implementing a quality improvement system that includes monitoring of complaints and quality of care concerns.
Education processes for staff to encourage patient safety practices	Formal processes were in place to educate staff about patient safety practices on an annual basis as part of the quality improvement program.	There were no formal education processes for staff to encourage patient safety practices.	Standard mandatory educational activities need to be identified and formalized by NHS using sign-in sheets to document attendance. An annual education plan also needs developed.

Category	Bond	NHS	Comments
Creation of a Culture, Organization, and Mechanisms that Promote Safe, High Quality Care, Continued			
Documented evidence of communication with specialists for coordination of care	Medical records reviewed did not show evidence of consultation reports being placed on the charts or of communication that may have been sent to specialists. A number of the records did indicate that referrals had been made.	The records consistently demonstrated evidence of communication of patients' status, medications, etc. were sent to the referred specialist physician. Evidence of consultation results were not always on the records.	Bond needs to ensure that the medical records contain documentation of materials sent to referred providers prior to the patient's visit. Both clinics need to ensure the timely receipt of consultation reports.
Mobilization of Community Resources to Meet Patient Needs			
Community resource manual available to the staff	Had an up-to-date community resource manual for staff use.	Had an up-to-date community resource manual that the social worker developed and used.	Both clinics have appropriate referral networks and demonstrate frequent use of many and varied community resources.
Documentation of any referrals to community resources (financial, support groups, psychosocial, etc.), community disease specific education classes	Documentation in the medical record demonstrated active discussions and referrals of members to community resources for screening, testing, and support.	Documentation in the medical record demonstrated active discussions and referrals of members to community resources for screening, testing, and support.	Both clinics' documentation showed referral of patients to an abundance of community resources. It was obvious to the reviewer that extensive coordination of care was being conducted. Both clinics also provide free care the medically underserved in a variety of community support residential and penal settings.

Category	Bond	NHS	Comments
Mobilization of Community Resources to Meet Patient Needs, Continued			
Documentation of referral of patients to free/discounted medication programs	Extensively used patient assistance programs to provide medications for patients.	Extensively used patient assistance programs to provide medications for patients.	Both clinics are saving the community significant pharmaceutical costs through their active use of patient assistance programs.

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Define Benefit Set

The County asked Mercer to design and estimate the cost for alternative benefit packages for covering a broader set of the County uninsured population.

The program structure can be evaluated against four determinants of risk:

- Program design,
- Covered population,
- Covered benefits, and
- Service delivery system.

Understanding how these elements relate to one another, generate trade-offs that need to be made, and influence the cost of the program is important to consider in designing a program to meet the needs of Leon County.

Program Design

In general, stakeholders believed the program should target uninsured low-income residents directly, serving both chronically and temporarily uninsured low-income Leon County residents. In order to enhance continuity in the program, participants would not be charged a monthly premium, but would participate in point-of-service cost-sharing through an income-based sliding-scale copayment system.

An overarching goal is improving health outcomes for low-income residents, using care management services to educate participants about their conditions and treatments, to assist participants in learning preventive and healthful self-management skills, and to assist participants in navigating the complex health care system to receive care in the most appropriate settings for their acuity level. Furthermore, improving health outcomes suggests that individuals begin to participate in the program before they experience a health crisis, which implies the program will need to include a significant marketing

component to "get out the word," rather than relying on referrals from providers once the patient is already in the system. Application and eligibility screening processes will need to be as convenient and as simple as possible while still ensuring that only those eligible are able to participate.

Decisions about program design clearly influence the costs of the proposed program. The lack of premium, for instance, should certainly provide more continuity of care for participants who might otherwise disenroll by failing to make their premiums. However, this feature means that relatively more costs are borne by the County. Sliding scale copayments at the point of service work in the opposite direction financially, as they cause some of the financial burden to be borne by the patient. Decisions related to the importance of care management functions and marketing may increase the program's administrative (i.e., non-medical) expenses, but may help reduce medical costs as they attract individuals into the system earlier, assist them in getting timely care in the right setting, and teach them about proper self-management.

Covered Population

A second element of risk in a health care program is the size and the nature of the covered population. Who is receiving services and what types of medical services do they use? The question is not just *Who is eligible to participate?* but also *Who among the eligible population will choose to participate?* Both will influence the costs of the program and the benefits that should be provided.

Eligibility for uninsured programs is often means-tested using the FPL; that approach is also recommended here. Eligibility is restricted to those individuals who are not otherwise eligible for a publicly-sponsored program, such as Medicare, Medicaid, KidsCare, or other public programs. Residents should be required to prove Leon County residency.

To estimate potential costs for the new program, three income thresholds for eligibility are used:

1. Up to 100% FPL,
2. Up to 150% FPL, and
3. Up to 200% FPL.

As all Florida children in households up to 200% of the FPL have an option to participate in one of the State's programs, the eligibility rules described imply the new County program will serve adults only, referring all children to the appropriate State program.

Finally, to mitigate the possibility of attracting individuals currently covered under employer-sponsored health insurance, we recommend the County consider implementing a "bare provision" in its eligibility requirements. Such a provision would state that

individuals are not eligible for program participation unless they have been "bare" of insurance coverage for a period of time (e.g., three or six months).

Covered Benefits

The set of medical benefits should be designed considering the population's medical needs balanced against available financial resources and provider networks. "Covered benefits" are those medical services the County will pay providers to deliver to a program enrollee. If covered benefits are not comprehensive, there may be other medical services the enrollee uses that are paid for out-of-pocket or borne by the provider as charity care.

Additionally, the effect of service exclusions on substitute services and on individual's behavior must be considered in designing a coherent benefit package. For instance, if inpatient care is a covered benefit, but facility outpatient is not, surgeries and other procedures that would be most cost-effectively performed as an outpatient procedure may move to an inpatient setting where reimbursement is available. Similarly, in considering whether and how to include Emergency Department (ED) services, we consider the implications for participants' choice of where to access care. If ED were not reimbursable by the program, but individuals are aware that they will not be turned away, they may have an incentive to go to the ED for non-emergent conditions to avoid the copayment associated with a covered physician visit. However, if ED is a covered benefit with a copay higher than the physician visit copay, participants may choose to visit the doctor rather than the ED.

Two possible benefit sets for the County to consider are outlined on the following pages; cost estimates for each set are provided in the next section of this report. The first package, "Leaner," is an expansion of the services currently offered through the County's clinic program, but is still far from a comprehensive medical services package. The package is oriented around primary care services and pharmacy, which can be provided either through the existing clinics or through other physician offices and pharmacies in the community. Specialist care and diagnostic tests (lab and x-ray) are also covered. There is no coverage for inpatient care, and non-emergent hospital outpatient services are limited to outpatient surgeries.

Option Name: LEANER
Enrollee Premium: NONE

Category of Service	Covered Service	Co-Pay Under 100% FPL	Co-Pay 100% - 150% FPL	Co-Pay 150% - 200% FPL	Benefit Limit
Inpatient Non-Maternity Physical Health	Not covered	Hospitals still at risk for uncompensated care as in current model			
Inpatient Non-Maternity Behavioral Health					
Inpatient Maternity					
Skilled Nursing Facility					
Outpatient Facility Physical Health					
Clinics	Same as current services	$2/visit	$0 wellness $15 chronic $20 acute	$5 wellness $20 chronic $25 acute	
Urgent Care Center	Yes	$2/visit	$15/visit	$20/visit	
Emergency Room	Yes	$50/visit	$50/visit	$50/visit	
Ambulance	Not covered				
Primary Care Physician (Non-clinic)	Yes	$2/visit	$0 wellness $15 chronic $20 acute	$5 wellness $20 chronic $25 acute	
Specialist Physician	With PCP referral only	$2/visit	$20/visit $75/OP surg in ofc	$25/visit $100/OP surg in ofc	
Physician Maternity Services	Over 185% FPL only[1]			$0/visit	
Outpatient Behavioral Health	Not covered				

Note: Highlighted are the suggested enhanced benefits not covered by the current system.

[1] Pregnant women with income <185% FPL are eligible for State-sponsored health care through the duration of their pregnancy; thus maternity costs are not included here at lower FPL levels.

Option Name: LEANER, Continued

Category of Service	Covered Service	Co-Pay Under 100% FPL	Co-Pay 100% - 150% FPL	Co-Pay 150% - 200% FPL	Benefit Limit
Pharmacy[2]	Yes; current formulary	Generic $0, Brand $2	Generic $10, Brand $15	Generic $15, Brand $20	Up to 7 scripts/ month
Family Planning	Physician services for prescription only	$0/visit	$0/visit	$0/visit	
Home Health	Not covered				
PT/OT/ST					
Chiropractor					
Podiatrist					
Dental	Exams, cleaning, x-rays, restorative, extractions only	$2/visit	$20/visit	$25/visit	
Vision	Medical only; No optometric or hardware	$2/visit	$20/visit	$25/visit	
DME & Supplies	Not covered				

[2] The pharmacy benefit is more comprehensive than what is currently provided.

Note: Highlighted are the suggested enhanced benefits not covered by the current system.

The second package, “Richer,” includes more covered services than Leaner, but is still less comprehensive than the typical employer-sponsored plan or Medicaid. This package includes all the services in the Leaner package, plus a limited inpatient benefit and an outpatient mental health benefit. No ancillary services (skilled nursing, home health, durable medical equipment, ambulance, therapy, chiropractor, podiatrist, etc.) are covered. Both packages include a sliding scale copayment structure for most services; however, the cost sharing in the Leaner package is higher than that incorporated into the Richer package.

Option Name: RICHER
Enrollee Premium: NONE

Category of Service	Covered Service	Co-Pay Under 100% FPL	Co-Pay 100% - 150% FPL	Co-Pay 150% - 200% FPL	Benefit Limit
Inpatient Non-Maternity Physical Health	Yes	$0/admit	$0/admit	$0/admit	Up to 8 days annually
Inpatient Non-Maternity Behavioral Health	Yes (MH only)	$0/admit	$0/admit	$0/admit	Up to 20 days annually
Inpatient Maternity	Over 185% FPL only[1]			$0/admit	
Skilled Nursing Facility	Not covered				
Outpatient Facility Physical Health	Listed diagnostics & OP surg; Pre-authorization required for PET, MRI, CT No blood or dialysis	$2/visit	Diagnostics: $5-25 depending on type $75 OP surg	Diagnostics: $10-$30 depending on type $100 OP surg	
Clinics	Same as current services	$2/visit	$0 wellness $10 chronic $15 acute	$5 wellness $15 chronic $20 acute	
Urgent Care Center	Yes	$2/visit	$15/visit	$20/visit	
Emergency Room	Yes	$50/visit	$50/visit	$50/visit	
Ambulance	Not covered				
Primary Care Physician (Non-clinic)	Yes	$2/visit	$0 wellness $10 chronic $15 acute	$5 wellness $15 chronic $20 acute	

Note: Highlighted are the suggested enhanced benefits not covered by the current system.

[1] Pregnant women with income <185% FPL are eligible for State-sponsored health care through the duration of their pregnancy; thus maternity costs are not included here at lower FPL levels.

Option Name: RICHER, Continued

Category of Service	Covered Service	Co-Pay Under 100% FPL	Co-Pay 100% - 150% FPL	Co-Pay 150% - 200% FPL	Benefit Limit
Specialist Physician	With PCP referral only	$2/visit	$15/visit $75/OP surg in ofc	$20/visit $100/OP surg n ofc	
Physician Maternity Services	Over 185% FPL only[1]			$0/visit	
Outpatient Behavioral Health	Yes (MH only)	$2/visit	$15/visit	$20/visit	Up to 20 visits annually
Pharmacy[2]	Yes; current formulary	Generic $0, Brand $2	Generic $10, Brand $15	Generic $15, Brand $20	Up to 7 scripts monthly
Family Planning	Physician services for prescription only	$0/visit	$0/visit	$0/visit	
Home Health	Not covered				
PT/OT/ST					
Chiropractor					
Podiatrist					
Dental	Exams, cleaning, x-rays, restorative, extractions only	$2/visit	$15/visit	$20/visit	
Vision	Medical only; No optometric or hardware	$2/visit	$15/visit	$20/visit	
DME & Supplies	Not covered				

Note: Highlighted are the suggested enhanced benefits not covered by the current system.

[1] Pregnant women with income <185% FPL are eligible for State-sponsored health care through the duration of their pregnancy; thus maternity costs are not included here at lower FPL levels.

[2] The pharmacy benefit is more comprehensive than what is currently provided.

For comparison purposes, the current benefit set is also shown, illustrating the significant differences between the existing program's benefits and proposed benefits. The proposed benefits would be reimbursed and delivered in a more coordinated manner (by an ASO) than what is currently occurring.

Benefit Level	Current System	Leaner	Richer
Covered Benefits			
Hospital Inpatient	○	○	◗
Hospital Outpatient	○	◗	◗
Diagnostic Services	◗	●	●
Physician/Clinic Services	◗	●	●
Outpatient Mental Health	○	○	●
Pharmacy	◗	●	●
Ancillary Services	○	○	○
Patient Cost-Sharing	Sliding scale	Higher	Lower

○ = Not covered ◗ = Limited Coverage ● = Covered

Service Delivery System

This refers to the network of providers and the care protocols used by those providers. The service delivery system affects program costs through provider reimbursement levels and utilization management services.

The County stakeholders expressed a desire to improve access to providers while maintaining the current provider structures that work well. To those ends, the cost estimates in the next chapter assume that the network of participating providers is broad; that is, any providers willing to accept the County's reimbursement as payment in full (plus any applicable patient copays) may participate in the program. Clinics, specialists who currently provide services to the uninsured, and the providers associated with the two universities are expected to continue to participate.

All participating providers will be subject to the care management protocols implemented by the County's administrative services vendor. Those care management protocols will be designed to ensure participants receive the most appropriate care for their conditions in the most cost effective settings. As part of this care management regime, we have assumed that covered specialist care is subject to referral from the patient's primary care physician.

We have not recommended or assumed that the County will implement any provider incentives (e.g., pay for performance) or any rewards to patients for healthy behaviors (screening tests, check-ups, weight loss programs, etc.). However, these types of program

features may be something the County will want to consider as a program enhancement once the program is underway.

Summary

Characteristics of Alternative Program Designs

Risk Element	Program Features Tested for Leon County
Program Design	▪ Targeted to low-income uninsured individuals ▪ No premium payment ▪ Point of service cost sharing; sliding scale ▪ Features designed to reach people early and guide them to appropriate care ▪ Non-emergent transportation services provided as appropriate
Covered Population	▪ Means-tested eligibility; three levels tested – Up to 100% FPL – Up to 150% FPL – Up to 200% FPL ▪ Documented residency in Leon County ▪ Not eligible for any other public health care program ▪ Risk control: ability to change eligibility requirements
Covered Benefits	▪ Strategic considerations: behavior and substitution ▪ Two packages evaluated; both expansions of current program but neither as rich as Medicaid or typical employer plans – Leaner – Richer ▪ Risk control: ability to change covered benefits
Service Delivery System	▪ Broad provider panel that includes providers who currently serve the uninsured population ▪ Strong care management function ▪ Gatekeeper (referrals to specialist required) ▪ Provider reimbursement and incentives controlled by the County ▪ Risk control: ability to change provider reimbursement

7

Price Benefit Set

Given the program design outlined in the preceding section, what will the County's expenditure level be? To answer this question, Mercer made enrollment projections and used actuarial models to estimate the potential costs associated with the two benefit packages and three eligibility thresholds described earlier. Viewing the results in the table below, vividly illustrates the tradeoff between providing more comprehensive services to fewer people versus providing a lower level of services to more people.

There is a wide range of potential program cost illustrated within this matrix, ranging from under $10 million in annual expense for providing the Leaner package to only residents with incomes under the federal poverty threshold (100% FPL) to over $20 million to provide the Richer plan to residents up to 200% FPL. These projections assume mature enrollment; first year costs would be lower as enrollment ramps up.

Table 1: Enrollment and Cost Projections for Alternative Benefit Packages and Eligibility Levels

Cost Levels based on January 1, 2007–December 31, 2007 Mature Enrollment

	Eligibility Thresholds		
	Up to 100% FPL	**Up to 150% FPL**	**Up to 200% FPL**
Projected Enrollment	***4,500***	***7,500***	***9,000***
Leaner Benefit Package			
Per capita monthly cost	$176	$157	$148
Annual expenditures	$9,504,000	$14,130,000	$15,984,000
Richer Benefit Package			
Per capita monthly cost	$225	$200	$192
Annual expenditures	$12,150,000	$18,000,000	$20,736,000

For both benefit packages, the per capita monthly costs decrease as the eligibility threshold increases. This result is due to two factors: 1) the sliding scale copay structure means that as income level increases, more of the cost is borne by the patient; and

2) income level is positively correlated with health status, which means that higher income enrollees are expected to consume fewer medical services.

The following tables show how these projected monthly costs are allocated among broad service categories for each of the two benefit packages. The impact of the sliding scale copay across the income levels and the impact of benefit differences between the two plan designs are more apparent when viewed at the service category level. In addition, these tables make it clear that most of the increase in cost between the Leaner package and the Richer package comes from the addition of the inpatient benefit.

Table 2: Estimated Per Capita Monthly Expense per Service Category and Eligibility Threshold

"Leaner" Benefit Package

Service Category	Up to 100% FPL	Up to 150% FPL	Up to 200% FPL
Hospital/Facility	$7.00	$6.75	$6.75
Clinic	$12.50	$11.50	$11.00
Professional	$65.25	$58.50	$55.75
Pharmacy	$65.25	$56.50	$52.50
Other	$1.25	$1.25	$1.25
Total Medical	***$151.25***	***$134.50***	***$127.25***
Administration*	$24.50	$22.00	$21.00
Total Expense	**$175.75**	**$156.50**	**$148.25**

Table 3: Estimated Per Capita Monthly Expense per Service Category and Eligibility Threshold

"Richer" Benefit Package

Service Category	Up to 100% FPL	Up to 150% FPL	Up to 200% FPL
Hospital/Facility	$45.25	$40.25	$39.75
Clinic	$12.50	$11.50	$11.00
Professional	$69.25	$62.00	$60.00
Pharmacy	$65.25	$56.50	$52.50
Other	$1.25	$1.25	$1.25
Total Medical	***$193.50***	***$171.50***	***$164.50***
Administration*	$31.50	$28.00	$27.00
Total Expense	**$225.00**	**$199.50**	**$191.50**

*Note: Administrative expenses include such items as carrier overhead, claims processing, utilization review/case management and program marketing.

The annual expenditures presented here are a function of both expected program enrollment and the projected per capita costs. As further described under "Cost Estimate Methodology" at the end of this section, the development of each of those components is based on data analysis, other internal and external research, and the judgment of Mercer's actuaries. Inevitably in analyses such as these, actuaries must make certain assumptions and data adjustments to generate the estimates. These assumptions, while appropriate for

the analysis, do represent a selection from a range of reasonable assumptions. The cost projections that result are best interpreted as point estimates within a range of reasonable results.

Projected Enrollment

The first step in projecting potential enrollment is to identify the number of uninsured individuals in the area and understand their characteristics. Knowing the characteristics of the local uninsured population will assist in customizing the per capita pricing as well as estimating the number who will meet eligibility requirements and will be interested in enrolling.

Counting the number of individuals without health insurance is a complex task, and reconciling sources with different estimates may be complicated by differing definitions of "uninsured." For the purposes of this analysis, we relied primarily on two sources of information: the U. S. Census Current Population Survey (CPS) results for the Tallahassee MSA (in which Leon County is included) and the 2004 Florida Health Insurance Study (FHIS). By combining these two sources we developed a reasonable range of the County uninsured population and examined the population's likely distribution by age and income level.

Analysis of three years of CPS data and 2004 FHIS survey results indicates that the current number of non-elderly Leon County residents without health insurance is probably between 22,300 (10% of population) and 31,000 (14% of population). This range is not as low as the 8% estimated by the 2004 FHIS, but still indicates Leon County has a low uninsured rate when compared with statewide and nationwide estimates (23% and 18%, respectively).[14,15]

As none of the evaluated scenarios would extend coverage to individuals with income levels higher than 200% FPL, and children at lower levels are all eligible for some type of State-sponsored coverage, we focused our attention on uninsured non-elderly adults. The corresponding range for uninsured non-elderly adults is 18,000 to 27,000, with a point estimate of 23,000. The remainder of the analysis is based on the point estimate of 23,000; however, it is important to understand that the width of the range of uninsured is a reflection of significant uncertainty. Please see "Cost Estimate Methodology" outlined at end of this section for more discussion of the topic. If the actual number of uninsured is toward the low end of the range, the resulting enrollment estimates may be too high. If the actual number is toward the high end of the range, the estimates may be too low.

[14] Urban Institute and Kaiser Commission on Medicaid and the Uninsured. Estimates based on the Census Bureau's March 2004 and 2005 Current Population Survey (CPS: Annual Social and Economic Supplements).

[15] The Deficit Reduction Act of 2005, signed by President Bush in February 2006, requires that individuals seeking Medicaid coverage produce proof of U.S. citizenship, effective July 1, 2006. It is unknown what impact, if any, this new requirement will have on the number of uninsured. The figures provided in this report make no adjustment for the potential impact of the Deficit Reduction Act.

Based on uninsured population characteristics outlined in the FHIS and CPS, approximately 7,800 (34%) of those uninsured individuals have income levels at 200% FPL or higher, which would mean they would be ineligible for the new County program at any of the eligibility thresholds evaluated. Thus, approximately 15,200 adult residents of the County could be eligible for the new program if it were extended to all residents with income levels up to 200% FPL.

However, in a voluntary program such as the one proposed here, participation rates generally fall far short of 100% of the eligible population, even when there is no monthly premium the participant must contribute. Our enrollment estimates have been guided by two principles:

- Research has shown that low income populations 'take up' free health care programs at a rate of 65-70%,[16] and
- Younger adults and higher income adults may have lower participation levels than the range cited above. The projections that follow assume 50% participation among 18-24-year-olds and among those with income levels between 150-200% FPL and 65% for other cells.

It should be noted that first year enrollment would be expected to "ramp up" over time and the following projections are for a period where the ramp-up has ended and enrollment has stabilized.

Table 4: Projected Program Enrollment by Age and FPL Level, Mature Program Period

Age Band	Under 100% FPL	100-150% FPL	150-200% FPL	Total
18 - 24	1,100	800	600	2,500
25 - 34	1,200	800	500	2,400
35 - 44	900	600	200	1,700
45 - 54	800	600	100	1,500
55 - 64	500	200	100	800
Total	**4,500**	**3,000**	**1,500**	**9,000**

Program enrollment can be influenced by a number of factors, including the aggressiveness and effectiveness of program marketing to the target population, the ease and simplicity of the application and screening process, and the initiative of health care providers to steer individuals toward the program if they present themselves for care and appear likely to be candidates for program participation. These factors and the resulting pool of program enrollees can have a significant impact on the expected per capita costs as well as the total number of enrollees. Those influences will be discussed further in the following section.

[16] See, for instance, Kaiser Commission on Medicaid and the Uninsured: "The Difference Different Approaches Make: Comparing Proposals to Expand Health Insurance" (1999).

Per Capita Monthly Cost Estimates

The second critical component of the cost projections for a Leon County uninsured initiative is the estimate of the expenses that will be incurred per enrollee, both medical and administrative expenses. Mercer used its health care cost projection models to develop the per capita costs shown above, incorporating the impact of each of the following program-specific elements:

- Characteristics of the expected enrollees,
- Covered services and care management impacts,
- Impact of point-of-service copays,
- Provider reimbursement levels, and
- Administrative costs.

Enrollee Characteristics

Individuals' medical needs are diverse, but actuarial projections of population expenditures are made by using population demographic characteristics that have been shown to correlate with medical expenditures. The key factors used in this per capita cost projection are age, gender, and income levels. The table in the previous section shows the ages and income levels of the assumed program enrollees. Income levels have been shown to be positively correlated with health status, so we adjust to reflect that lower morbidity level when we consider the impact on per capita costs of successively higher eligibility thresholds. As the uninsured data sources we consulted showed the Leon County uninsured population was relatively evenly split between men and women, we assumed this even gender distribution in our pricing.

The term "selection effect" describes the cost impact that may be experienced if the individuals who enroll in a particular program are significantly different than the average eligible population. *Positive selection* refers to the effect of healthier than average individuals enrolling in a product, and *adverse selection*, or anti-selection, refers to the effect of sicker than average individuals enrolling in a product. In the pricing of a new type of product targeted to the currently uninsured population, the concern is for the potential for adverse selection.

The potential for adverse selection is often evaluated as it is associated with program participation levels, and is influenced by the level of premium that must be paid. There is no premium required under this proposed design, but there is an application and eligibility screening process that may discourage some of the healthier members of the eligible population from enrolling. As a result, it was appropriate to consider and incorporate the potential per capita cost impact associated with many people not enrolling in the program until experiencing the need for medical care. This effect is reflected both in the projected enrollment numbers (lower than otherwise) and in the expected per capita cost estimates (higher than otherwise).

Covered Services and Care Management Impacts

The set of covered services is a key modeled element in the development of per capita costs. Actuarial models start with a baseline utilization patterns for comprehensive medical services, and make adjustments for the cost impact of excluding or limiting certain services. The services covered under the Leaner and Richer benefit packages are summarized in the *Define Benefit Set* section. With the exception of maternity services, covered benefits and benefit limits do not vary by FPL level in these designs.[17]

Pricing must also consider the impact that care management functions have on expected medical expenditures. A key component of this proposed program is a strong care management element that will assist participants in accessing appropriate preventive services and identifying the most appropriate treatment settings for their acuity level. By design, this function is expected to change the way individuals use medical care, so those changes must be reflected in the cost estimates. In particular, Emergency Department (ED) use for primary care is assumed significantly lower than in an unmanaged environment, and primary and preventive care provided in clinics and physicians' offices is assume to increase. Use of dental care services is also projected to increase.

Point of Service Copays

Both the "Leaner" and "Richer" benefit packages include a sliding copay scale to lower out of pocket costs for lower income individuals. Point of service copays are incorporated into pricing estimates in two ways: the share of the cost borne by the individual lowers the cost funded by the County, and the presence of a copay lowers demand for some types of services, also lowering the County's funding requirements.

Provider Reimbursement

The rate at which providers are compensated for the care they provide is a key element in the cost the County will incur. Reimbursement requirements depend on the local health care environment, and our understanding is that Leon County will work with local providers to establish reasonable reimbursement arrangements. In order to develop the cost estimates provided in Table 1, we made certain assumptions about what those provider reimbursement levels might be. To do this, we relied heavily on stakeholder insight on the Leon County medical marketplace. Key considerations discussed were the access available to various types of providers in the community at current Medicaid and Medicare reimbursement levels, and the current reimbursement levels made by the County, where applicable. To the extent that eventual negotiated arrangements for the program differ from our assumptions, actual experience may be higher or lower than our projections.

[17] As pregnant women with income levels below 185% FPL are eligible for State programs at least through the duration of pregnancy and a post-partum period, maternity services need be covered only in the highest income band considered (150-200% FPL).

The projected costs incorporate no assumed volunteer contribution to providing health care to this population. To the extent that current volunteer initiatives continue or are expanded, the cost of the program would be lower than the projections shown.

Administrative Costs

Finally, the last element of the per capita estimation is the expected administrative load. Administrative expenses, sometimes referred to as non-medical expenses, include such items as carrier overhead, claims processing, utilization review/case management, and program marketing. The level of non-medical expenses is influenced by the targeted population and the method of product offering, among other things. For this proposed program, non-emergent transportation for patients to facilitate care access is considered a non-medical expense as well.

While some administrative costs are relatively fixed (e.g., marketing, other overhead), others vary by the size and morbidity of the enrolled population (e.g., claims processing, utilization review/case management). Administrative costs are typically expressed as a percentage of premium (total cost). The per capita cost projections in this analysis are based on an estimate that administrative costs would comprise approximately 14% of total costs.

Benchmarks

In evaluating the cost estimates provided, it may be helpful to compare those results to certain other health care coverage benchmarks. While the benchmarks provided here represent programs or products with important differences from the priced program, they are still useful to compare to the projections to understand how this program may compare with other types of health care coverage.

Enrollment

An important benchmark for the enrollment projection is a comparison to the number of individuals currently served under the County Primary Health Care program, which has an income threshold of 150% FPL. The number of bona fide Leon County citizens receiving care for which Leon County Primary Health Care funds are expended is shown in the following table. Numbers in the table do not represent unduplicated patients across providers; in particular, most of the individuals served through the WeCare providers would be represented in the clinic figures.

Table 5: Leon County Residents Receiving Care through the County's Primary Health Care Program

Provider	FY 2001–2002	FY 2002–2003	FY 2003–2004	FY 2004–2005
Bond	1,206	1,880	5,159	4,073
NHS	802	1,695	1,405	2,878
WeCare	503	635	624	773

Source: Leon County Health and Human Services Staff

We have collected two different benchmarks for the estimated per capita monthly cost associated with medical services and administration, as shown in the table below.

Benchmark Per Capita Monthly Health Care Costs for Adults

	Base Data	2007 Estimate
Florida Medicaid capitation rates[18]	$190	$225
Small Group HMO rate[19]	$308	$347

Medicaid Capitation Rates

The first of these, the composite adult capitation rate used by the state Medicaid program to purchase managed care coverage for its Temporary Aid for Needy Families (TANF) eligibility group during state fiscal year (SFY) 2004-2005, is $190. Applying an aggregate 7% trend to put this value on a calendar year (CY) 2007 basis for comparison purposes produces a benchmark of $225 per month to provide Medicaid services to adult recipients, similar to the highest estimated monthly cost in the matrix above (the Richer benefit package for the lowest eligibility threshold). The Medicaid package is generally more comprehensive than the benefit package evaluated here, but the cost of the additional benefits in the Medicaid figure is offset somewhat by higher primary care reimbursement levels and adverse selection impacts in the proposed program estimates.

Small Group Rates

The second benchmark is the rate that might be charged for small group coverage of a 45-year-old under a small group health insurance policy in Leon County (on a total premium basis, thus comprising both the employer contribution plus the employee contribution). The $308 rate for a 12-month contract beginning October 2005 would be $347 if trended to CY 2007 using the filed trend. This rate is significantly higher than the projected per capita rate for the proposed program, reflecting both a more comprehensive benefit package and commercial provider reimbursement levels. Copay levels for this product are similar to those outlined for the highest income category for the Leaner benefit package (e.g., $15 PCP copay, $25 Specialist).

[18] Mercer aggregation of Medicaid Districts 1 and 2 adult capitation rate cells, TANF eligibility category, for SFY 2004-2005, accessed online March 30, 2006, at *http://ahca.myflorida.com/MCHQ/Managed_Health_Care/zipped_files/AppendixA_0405.zip*, Appendix A1.

[19] Based on the rate filing for a popular small group HMO benefit package, accessed online from the Florida Office of Insurance Regulation at *www.floir.com*. To put this rate on a comparable basis to the projected cost estimates for Leon County, Mercer adjusted for a 45-year-old adult using the filed age/sex factors.

Cost Estimate Methodology

The following expands upon the methodology Mercer used to develop the program cost estimates provided at the start of this section.

Enrollment Projections

Mercer used two primary sources to identify the potential number of Leon County residents who would be eligible for the coverage initiative at three evaluated income levels: the Current Population Survey (CPS, from the U.S. Census Bureau) and the 2004 Florida Health Insurance Study.

CPS

CPS is the most frequently used source of information on the uninsured population in studies across the country, and it is the only national survey with a large enough sample size to allow for valid state-specific extracts. CPS captures information about all types of health insurance coverage in the surveyed households during the prior calendar year. Consequently, multiple coverage types can be captured for the same individual and CPS estimates of the uninsured population are supposed to represent the individuals who had no health insurance coverage during the entire year. However, many researchers have opined that the CPS results correspond more closely to other surveys' "point in time" estimates of the uninsured.

CPS is known to undercount Medicaid recipients when compared to administrative data that state Medicaid agencies submit to CMS. 2005 saw the publication of a number of research articles on this topic, and simulations are currently underway to explore the implications of this undercount on other market segments, particularly the uninsured. Mercer has made no specific adjustments to the CPS data for this undercount, but rather considered the potential implications in developing the reasonable range of uninsured to use for analysis.

High level queries of CPS are available through an online query system at the Census website at *http://www.census.gov/hhes/www/cpstc/cps_table_creator.html* (as of March 30, 2006). More detailed queries require the use of the Census's Data Ferret data base tool, available for public use via download of the tool from the CPS Web site. In order to study the size of the uninsured pool in the County and the relationships among age and income level of those individuals, we used three years of data (2002-2004) for the Tallahassee MSA. Using three years of data enhances the credibility of the overall results, and we found the CPS data on the number of uninsured individuals to be relatively credible. However, the CPS sample size at the Tallahassee MSA level was small enough that certain data drill-downs to identify characteristics of the uninsured population were not credible. Therefore, our primary use of the CPS was to provide a secondary source about the number of uninsured individuals.

2004 Florida Health Insurance Study (2004 FHIS)

The 2004 update to the 1999 FHIS was funded by a State Planning Grant from the U.S. Health Resources and Services Administration, with state-level oversight by the Florida Agency for Health Care Administration. The survey was designed and conducted by the University of Florida. Results of the study are available online at *http://ahca.myflorida.com/Medicaid/quality_management/mrp/Projects/fhis2004/reports.shtml* (as of March 30, 2006).

The 2004 FHIS estimated the non-elderly population uninsurance rate at the county level, and provided age and income level statistics for the uninsured population at a "district" level. The 2004 FHIS classified Leon County as a member of District 1, along with Bay, Escambia, Gadsden, Okaloosa, and Santa Rosa counties.

The 2004 FHIS estimated that approximately 7.7% of Leon County's non-elderly population was uninsured during the data collection period in 2004, which suggested a count of approximately 18,000 individuals. (County-level estimates were not published as part of the 1999 FHIS; so, only one year of results is available.) This proportion represented the lowest uninsurance rate of any county in the state at that time. CPS three-year results suggested a significantly higher proportion – over 15% of the non-elderly population could be without insurance in the Leon County area. While it is possible that this number is somewhat high as a result of the Medicaid undercount, there is risk of underestimating the budget impact of the program if the 2004 FHIS understates the proportion of the population that is uninsured. As a result, we have characterized the uninsured count as a significant area of uncertainty, and presented a range of between 10% and 14% of non-elderly population as the basis for our analysis.

In order to understand the demographic characteristics of the uninsured population, we relied on the 2004 FHIS District 1 population characteristics. Using these, we estimated the size of the adult uninsured population (a point estimate of 23,000 results) and how those individuals may be allocated among different age bands and income levels. Finally, we applied the participation/enrollment assumptions specified in the report to generate a projection of enrollment at different eligibility thresholds. That projection is shown in Table 1 of the *Price Benefit Set* section.

Per Capita Cost Estimates

Mercer used an actuarial pricing approach to project costs for each of the two benefit packages evaluated. This type of approach starts with a base set of medical service and cost data and makes various actuarial adjustments for expected differences between the base and the evaluated package, including differences in population, covered services, cost sharing elements, service delivery mechanism, and time period.

The base data used for this analysis reflects medical service utilization of low income populations. Provider reimbursement was adjusted to a Medicare basis or state Medicaid basis, as necessary, by comparing base data fees to published Medicare and Florida

Medicaid fee schedules for market basket sets of services. Adjustments made to the base data for the above-specified design elements were based on data analysis, other internal and external research, and the judgment of Mercer's actuaries. The adjustments are appropriate for the type of analysis performed; they do, however, rely on assumptions that are selections from ranges of reasonable assumptions. The cost projections that result, and are shared above, are best interpreted as a point estimate within a range of reasonable results. Actual results experienced would be certain to differ to the extent that assumptions are not precisely realized in fact.

8

Analysis of Potential Program Benefits and Costs

Providing access to affordable health insurance to some of the uninsured population in the County may result in significant benefits to the community; however, these benefits will require financial support. Specifically, one method to fund this would be a half-percent increase to the County's sales tax. Following are some key potential benefits and costs from this program.

Potential Program Benefits

While it is well-documented that having health insurance leads to better access to needed care and better health outcomes for individuals, the community-wide benefits of insuring previously uninsured persons may be less obvious. This section outlines potential benefits of providing health insurance to the previously uninsured in the Leon County community.

Businesses

Businesses will realize several benefits from an increase in the number of insured persons in the County. First, businesses that offer health insurance to their employees often pay a significant portion – and in some cases, all – of their employees' health insurance premiums. Health insurance premiums have been rising much faster than inflation, which has put a financial squeeze on employers, forcing many of them to make difficult decisions about the extent of the coverage they can provide to their employees and the amount that they can contribute to the coverage. Not only does the increase in premiums force difficult business decisions, employers, like their privately insured employees, are paying the hidden "premium tax" that results from uncompensated care. Employers that offer health insurance to their employees are, in essence, subsidizing other employers that do not provide health insurance. To the extent that insurance companies can negotiate better rates with providers – as these providers will see more insured patients and be reimbursed for care that was once uncompensated – businesses that offer health insurance may see some relief from the staggering increases they are experiencing in health insurance premiums for their employees.

Businesses should also realize productivity gains from an insured workforce. Research suggests that having health insurance is associated with overall better health and facilitates a person's ability to access needed care in a timely manner. It has also been shown that employers experience additional costs associated with absenteeism and lower productivity when their workers are in poor health.[20] Therefore, employers with insured workers should have a healthier and more productive workforce. In addition, health insurance affords workers access to preventive care, which assists them in maintaining their long-term health and productivity.[21]

Insured Residents

Hospitals and other health care providers are often left with a revenue shortfall as a result of providing uncompensated care and must look to other payers to relieve this financial strain. Because hospitals and other providers generally cannot shift costs to government payers, they must look to private health insurers to fund the costs of providing uncompensated care. Private insurers pay higher rates to providers, which are then reflected in higher health insurance premiums for the privately insured. In the County, that translates to less than 65%[22] of the population bearing the costs for all compensated care that is not otherwise supported through government and philanthropic programs.

One national study recently attempted to quantify the additional amount each insured individual and family covered under employer-sponsored health insurance pays as a result of uncompensated care provided to the uninsured. The study estimates that, in Florida, annual individual premiums increased by $468 and family premiums increased $1,313 for 2005 as a result of providing uncompensated care to Florida's uninsured.[23] This, again, essentially amounts to a hidden "premium tax" on private health insurance. To the extent that more persons are insured and providers are not forced to pass along uncompensated care costs, this "premium tax" may be somewhat mitigated.[24]

[20] O'Brein, E. (2003). Employers' Benefits from Workers' Health Insurance. *The Milbank Quarterly*, 81(1).

[21] Families USA. (2005). "Paying a Premium: The Added Cost of Care for the Uninsured." *http://www.familiesusa.org/resources/publications/reports/paying-a-premium.html*

[22] The estimate of 65% of Leon County residents carrying private insurance is based on the 2004 Florida Health Insurance Study, which surveyed Floridians on their source of insurance coverage. In District 1, which includes Bay, Escambia, Gadsden, Leon, Okaloosa, and Santa Rosa counties, 52.5 percent of respondents reported carrying employment based insurance and 10.1 percent of residents reported carrying individually purchased insurance. See "2004 Florida Health Insurance Study Telephone Survey Findings," a presentation made to Congressman Boyd's North Florida Regional Health Council Meeting by Mel Chang, ACHA Administrator on September 19, 2005.

[23] Families USA. "Paying a Premium: The Added Cost of Care for the Uninsured."

[24] It is important to note that these "premium tax" estimates are aggregate for the entire state of Florida and actual cost-shifting to cover uncompensated care in Leon County could be significantly different. In addition, because not all uninsured persons in Leon County would be covered under this proposal, the extent to which the hidden "premium tax" could be alleviated may be significantly less than the total amount of the "tax."

Providers

There is a negative financial impact on providers serving patients without health insurance. National research indicates that patients, who are uninsured throughout the entire year, on average pay out-of-pocket for 35% of their care, leaving over 60% of their care uncompensated.[25] While federal, state and local governments, as well as private institutions, assist hospitals and other providers to cover the cost of providing services to persons who are unable to pay, these sources generally do not provide enough funding to fully cover the costs.[26] Providers are then left with the unenviable options of absorbing the costs or shifting the costs to another payer.

Leon County hospitals reported over $20 million in uncompensated charity care in 2004.[27] This amount does not include uncompensated care provided by physician practices, clinics and other health care providers; therefore, this amount underestimates the total amount of uncompensated charity care health care professionals in the County provide. While no estimate is available of the extent to which non-hospital providers in Leon County provide uncompensated charity care, it is significant. One national study estimates that non-hospital providers provided approximately 37% of all uncompensated care in 2001.[28] This is consistent with a study by Maine's Year 2000 Blue Ribbon Commission on Health Care, in which researchers found that non-hospital providers accounted for 36% of the total charity care and bad debt associated with care for uninsured Mainers.[29] If these estimates held true for Leon County in 2004, non-hospital providers in the County would provide between $12 and $13 million in additional uncompensated care. Together, charity care in Leon County could have reached almost $35 million in 2004. To the extent that more of the County providers' patient base is insured – by expanding health insurance options for the uninsured – the less necessary it will be for these providers to absorb uncompensated care costs or look for increased payments from other payers.

Some states have already realized savings by expanding health insurance coverage and thereby reducing the amount of uncompensated care. For example, some participants in Maine's Dirigo program – which provides access to affordable health insurance for employees of small businesses, the self-employed and other individuals – were previously

[25] Hadley, J., Holahan, J. (2003). "How Much Medical Care Do the Uninsured Use, And Who Pays for It?" *Health Affairs* web exclusive, http://content.healthaffairs.org/cgi/content/full/hlthaff.w3.66v1/DC1

[26] Ibid.

[27] The Florida Hospital Uniform Reporting System defines uncompensated charity care as, "that portion of hospital charges reported to the Agency for Health Administration for which there is no compensation, other than restricted or unrestricted revenues provided to a hospital by local governments or tax districts regardless of the method of payment for care provided to a patient whose family income for the twelve months preceding the determination is less than or equal to 200 percent of the FPL, unless the amount of the hospital charges due from the patient exceeds 25 percent of the annual family income. However, in no case shall the hospital charges for a patient whose family income exceeds four times the FPL for a family of four be considered charity."

[28] Hadley, J., Holahan, J. "How Much Medical Care Do the Uninsured Use, And Who Pays for It?"

[29] Year 2000 Blue Ribbon Commission on Health Care. (2000). "The Cost of Health Care in Maine: An Analysis of Health Care Costs, Factors that Contribute to Rising Costs, and Some Potential Approaches to Stabilize Costs."

uninsured or underinsured. Mercer calculated the savings that resulted from covering those individuals and reducing the amount of uncompensated care they received. In the first year of the program, we estimated savings of approximately $2.7 million.[30]

Uninsured Residents

Uninsured residents of Leon County are the persons most directly affected by the lack of health insurance. It has been well-established that a lack of health insurance leads to delaying – or not receiving at all – needed medical care. Persons without health insurance also have generally poorer health.[31] Evidence suggests that poor health leads to lower workforce participation and personal income, which has a direct financial impact on the uninsured.[32] Persons without health insurance can also face serious problems with medical debt. In a 2002 survey, 44% of uninsured adults reported having a serious problem paying their medical bills, as opposed to only 14% of insured adults.[33] Providing health insurance to the previously uninsured in Leon County should have the effect of improving both individual financial situations, as well as increasing the potential productivity of part of the County's workforce.

Funding Alternatives[34]

There are a number of funding alternatives available to support this initiative. Here is a brief summary of possibilities.

Primary Healthcare Municipal Services Taxing Unit (MSTU): The County currently levies a countywide property tax of 0.12 mils to support their health care program. Under the enabling ordinance, the County has the ability to levy up to 0.5 mils for the primary health care program. Based on current property valuation estimates, 0.5 mils would generate approximately $6.2 million annually. To increase the millage rate beyond 0.5 would require a change to the enabling ordinance and the consent of the city of Tallahassee.

Countywide Millage Rate: Under Florida law, Leon County is able to levy up to 10.0 mils countywide. The County currently levies 8.54 mils. The existing capacity is 1.46 mils. Increasing the levy to 10.0 mils would generate approximately $18 million annually.

[30] Mercer Government Human Services Consulting. (2005). "Dirigo Health Savings Offset Payment: Methodology and Calculations." *http://www.state.me.us/pfr/ins/dirigo_health_filing.htm*

[31] Kaiser Commission on Medicaid and the Uninsured. (2003). "The Uninsured and Their Access to Health Care." *http://www.kff.org/uninsured/1420-05.cfm*

[32] Hadley, J. (2003). Poorer & Sicker – The Consequences of Being Uninsured: A Review of the Research on the Relationship of between Health Insurance, Medical Care Use, Health, Work, and Income. *Medical Care Research and Review*, 60(2), Supplement to June 2003.

[33] Kaiser Commission on Medicaid and the Uninsured: "The Uninsured and Their Access to Health Care."

[34] Leon County Office of Budget and Management discussions in April, 2006.

Utilization of Existing Resources: The County could reduce and/or eliminate other programs currently funded through general revenues. The County's adopted FY 2006 general fund budget is $50.9 million.

½ Cent Sales Tax: Under Florida law, Leon County is authorized to levy an additional ½ cent sales tax to support indigent health care. The tax needs to be approved through the referendum process. The tax would generate approximately $18 million annually. While Mercer has not extensively analyzed the County's budget, the sales tax does present a reasonable funding opportunity for this initiative.

Potential Program Costs

While evidence suggests that providing health insurance could result in significant positive impacts for the community, it does come at a financial cost. Under this proposal, the County would use a half-percent sales tax to raise some of the funds needed to implement this insurance initiative. The County estimates the sales tax will result in an average annual cost of $52 to $59 per County resident.[35]

There are two potential concerns with this tax. First, sales taxes can be regressive – namely, lower-income persons may feel disproportionately more burden from the tax than do higher-income persons. Specifically, a sales tax that is applicable to essential items affects low-income individuals to a greater degree because they must spend more of their incomes on these essentials than do higher-income individuals. Given that this insurance initiative targets low-income individuals, the sales tax – to the extent that it applies to non-luxury items – could disproportionately affect the population it seeks to serve. However, the Florida sales tax does not apply to some essentials, such as groceries and prescription drugs, so the impact of the sales tax increase on low-income individuals is somewhat mitigated in this case.

Second, a sales tax increase raises concerns over its potential impact on the local economy. While the tax would increase revenues on the existing tax base, there is concern that it could cause the overall tax base to contract, thereby negating the goal of additional revenue generation. For example, evidence exists that consumers engage in cross-border purchasing, leaving their home areas and traveling to jurisdictions with lower tax rates to make their purchases. This behavior can have the effect of reducing the tax base in their home areas by lowering overall sales.[36] In addition, businesses may consider relocating to other areas with lower tax rates or passing the effect of the sales tax increase onto consumers, potentially decreasing overall economic activity.[37]

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[35] Estimates were provided by the Office of Budget and Management of Leon County. Note: the actual cost to any one individual is dependent upon the taxable purchases the individual actually makes.

[36] See Luna, L. (2004). "Local Sales Tax Competition and the Effect on County Governments' Tax Rates and Tax Bases." *The Journal of the American Taxation Association*, 26(1). and Walsh, M., Jones, J.D. (1988). More Evidence on the "Border Tax" Effect: The Case of West Virginia, 1979 -84. *National Tax Journal*, 41(2).

[37] Poterba, J.M. (1996). "Retail Price Reactions to Changes in State and Local Sales Taxes." *National Tax Journal*, 49(2).

The net effect of an increased sales tax on any particular local economy, however, depends greatly on the characteristics of the area, such as its proximity to other jurisdictions with lower tax rates, the location of urban centers, and the preferences of consumers.[38] Based on several factors unique to Leon County, it appears likely that the half-cent sales tax increase in the County will not have a significant negative economic impact for several reasons. the County's sales tax rate would be increased to 8%, which is a point higher than the sales tax rates in neighboring counties (in both Florida and Georgia). However, Leon County is home to Tallahassee, the largest city in the immediate area. Businesses dependent upon the consumer base of the Tallahassee area are not likely to move to a neighboring county for a one cent decrease in the sales tax because the decrease in taxes would not offset the loss of some or all of their customer bases. In addition, consumers still have an incentive to continue purchasing from businesses located in Leon County even though the sales tax is higher than in neighboring areas. Consumers, who are accustomed to the diversity in retail options that can only be supported in a highly populated area, are not likely to give up that diversity to shop in less urban neighboring jurisdictions solely due to a lower sales tax rate.[39] In addition, the savings consumers would realize from shopping in neighboring jurisdictions with lower sales tax rates would have to outweigh consumers' transportation costs in traveling to these areas. Given the current high costs of transportation, it is unlikely consumers will be willing to travel very far for a one cent sales tax savings. Finally, the extra half-cent increase will introduce new money into the County through taxable purchases made by tourists. The County estimates that 22% of taxable sales will be generated by tourists, who are not residents of the County. While there is potential for the sales tax increase to affect economic behavior – some consumers may decrease their spending and some in border areas may make purchases in other jurisdictions – the overall effect on the economy is likely to be minimal and the tax should generate additional revenue to help fund this initiative.

[38] Luna, L. "Local Sales Tax Competition and the Effect on County Governments' Tax Rates and Tax Bases."

[39] This scenario was evident in a study conducted in Oklahoma in which researchers estimated the effects of an increase in the sales tax rate in Oklahoma City on sales in both the City and the surrounding areas. They found that sales in Oklahoma City and the surrounding areas either did not change or increased slightly after the implementation of the sales tax. See "Impact of City Sales Tax Increases: A Study of Four Regions in Oklahoma" by T.K. Bhattacharya and A. Sukar in the Oklahoma Business Bulletin, December 1992.

9

Model Recommendations

Stakeholder comments reflect a wide range of interests in terms of what the recommended health benefit model should contain. Some areas of interest – having a comprehensive range of service, with accessible services, at a low cost – are in conflict with each other. As in any economic equation, there will be tradeoffs. Specifically, achieving a low cost health benefit will to a certain extent necessitate tradeoffs in the range of benefit coverage, the level of provider reimbursement, or beneficiaries' access to providers. It is simply not possible to exactly meet all stakeholder interests in whatever model is recommended. Achieving an acceptable balance of tradeoffs will be key to success. This situation is not unique to health care in Leon County.

In viewing the three models discussed in detail earlier in the report, each has its strengths and weaknesses when compared to stakeholder goals. No one model is a precise match to meet these goals. Rather, each model has characteristics to contribute to the recommended model for the County. Following are the key criteria used in recommending a model for Leon County.

Guiding Principles for Model Design

Budget stability and predictability is one of the key stakeholder goals. As the program is being funded by tax dollars, it needs to stay within the budgeted amount. One of the true challenges in health care today is trying to slow the rapidly rising costs of health care. Of concern is the magnitude by which these costs increase faster than the general rate of inflation. Given the current reality of rapidly increasing health benefit program costs, no model can by itself fully address the issue of budget predictability. The "product" will need to have built-in mechanisms and ongoing refinement to help mitigate the impact of health care inflation. While the clinic model currently achieves county budget stability, it does so to a certain extent by placing the participating clinics at financial risk through use of a budgeted funding approach.

The model should build on existing best practices and preserve the attributes of the existing program. A desire to enhance the current program and to bring in change incrementally was expressed by some of the stakeholders. It does make sense to build on effective practices and infrastructure that are currently in place.

Leon County Oversight

There needs to be a strong element of county government accountability and control. Given that the ultimate accountability is to taxpayers, the administration will need to react quickly to emerging issues within the County. The model needs to have the required flexibility to accommodate this. An example of this situation could be if a change in benefits was required in the middle of the year. Once approved by the Board of County Commissioners, the County would want the ability to implement this change without a significant amount of further discussion/negotiation with their health care vendor. The ability to do this is greater in the clinic or ASO models.

To meet its responsibility to taxpayers, the County also will need to have the ability to measure the performance of the program and to provide reports on key metrics. Being able to provide answers to questions, such as:

- What is the quality of care of our program?
- Is it cost-effective?
- Are recipients receiving the care they need?
- Is the health of this group improving?

While all of these answers will not be immediately available, the County will want to consider designing a reporting system that tracks appropriate information and allows it to answer these questions. Currently, the ability to do this will be found in the infrastructure contained in a health maintenance organization or ASO models. With additional funding, the clinic model could further enhance their infrastructure to have the same capacity.

Implementation

The selected model should be brought to market in a timely manner, i.e. requiring minimal start up or ramp up time. Once an additional tax is approved by the tax payers, there will likely be expectations of implementing the program in the immediate future. A larger provider network will be required to serve a larger population than is currently being covered. Significantly increasing infrastructure will be a key task in the implementation process. This means there will need to be:

- More providers in the network,
- A stronger information system to track claims and quality of care indicators, and
- A strong case management system.

An HMO or ASO model will be able to immediately provide this needed infrastructure. Assuming the County does significantly increase the size of the program, the HMO or ASO model will be best suited to meet this need.

Integration

Avoiding "crowd out" – a situation where residents currently have health care insurance, but drop that coverage so they can be covered by the County's program – is a significant concern. There are a variety of methods employed in other programs to try to control this, none of which are 100% successful. Nonetheless, this issue requires significant attention to avoid the predicament where the County ends up providing coverage to those who previously had coverage from a different source. Design features to incorporate in the model:

- A "leaner" benefit set than exists in the marketplace, to decrease the incentive for employees to leave existing insurance for the County-based program;
- Funding providers at appropriate reimbursement levels – typically below commercial rates; and
- Implementing eligibility requirements.

The model should integrate community supports, including existing provider participation and county and federal funding. To the greatest extent possible, what is already working well should be emphasized in moving the program forward. The interest and dedication of the community in serving this population should continue to be a core component in the future health care delivery model used in Leon County. In the current environment, the clinic-based model is the best in accomplishing this goal among the current options.

Type of Model

Based on these criteria and marketplace considerations, Mercer recommends the County should implement an ASO model as the basis for providing care to the currently uninsured. To build on this model's strengths in terms of implementation and County oversight, the model will need to incorporate the following features to enhance it in order to better integrate with existing programs and to minimize the model's financial risks associated with its product design.

Additional Model/Program Features

- ***Mandate that existing clinics currently providing care to the uninsured are part of the primary care network.*** These clinics should continue to be part of the model's network and continue to serve this population.
- ***Provide a minimum benefit set to better use existing financial resources to care for a larger portion of the population.*** The trade-off is a less comprehensive benefit set, but more people will have health care coverage.

- ***Minimize financial risk to the County by building in "levers" that can be accessed if needed.*** The County needs to have the ability to:
  - *Change or limit program eligibility.* This can be done by basing eligibility on income level (or FPL).
  - *Change or limit the benefits offered by the plan.* The benefit package should include internal limits to protect the County against financial risk associated with very high-cost users. Typically, any changes would be made at the end of the year to minimize confusion and maintain program continuity.
  - *Reimburse providers using budgeted funding where possible.* While it will be necessary to pay near-market rates for some types of providers to ensure an adequate network, that will not be true for all County providers. Where possible, the County should contract with hospitals and other provider groups at a pre-determined annual budget to provide care for eligible recipients throughout the year. This will provide greater budget stability to the product.
- ***Maximize existing funding sources***. There is a strong desire for Bond and, if possible, NHS to continue to access Health Resources and Services Administration (HRSA) funding opportunities as well as State Department of Health (DOH) match grants.
- ***Emphasize preventive services***. A primary reason for the County to provide an insurance product is to ensure people are being seen at the appropriate point of contact in the system and in a timely manner before a person's health care status deteriorates.
- ***Emphasize and incorporate model components which efficiently and effectively use available resources.***
  - For example, the County should mandate the development of a formulary which specifies that, if available, generic drugs should be administered.
  - The County should incorporate a strong, medical management component into the model to ensure coordination of care within the system.

Should the County move forward with an ASO model, the following components should be considered for incorporation in the model. These components are guidelines to consider. Changes in benefits offered (i.e. inpatient hospital coverage and the need for concurrent review) will affect which components should be covered.

Managed Care Strategies Included in an ASO-Only Vendor Contract

Service Access

- Network development to meet the primary and specialty needs of the population. Assure adequate rural and urban geographic access to providers in general and specific provider types (i.e., various specialists) and performance requirements. Assure adequate access to family planning services in or out of network.

- Adequate appointment access for emergent, urgent, and routine services and performance requirements. Service and/or resource development including evidence of network strategy, planning efforts including projected member needs and assessment of unmet needs/gap analysis.
- Availability of web-based registration service
- Development of service vendor listing and community-based resources list
- Inpatient census reporting
- Ability to access out-of-network providers, including a mechanism to assure payment rates and member financial responsibility is not impacted. Single case agreements for non-network providers of essential services.

Quality Improvement

- Quality improvement annual review and data trends
- Quality improvement studies
- Consumer, family, and other client satisfaction surveys
- Provider satisfaction surveys
- Quality management plan development, implementation, and performance requirements
- Participation on quality committees
- Corrective action plans (CAPS) and performance improvement plans (PIPs)
- Critical incident management and reporting
- Complaint and grievance trending
- Over- and under-utilization monitoring
- Process, policy and procedures for oversight monitoring of quality programs for any vendors providing services

Utilization Management

- Utilization management plan development and implementation and performance requirements
- Prospective, concurrent, and retrospective utilization management
- Detection and management of high-risk/high-utilizers
- Establishment of medical necessity criteria, level of care guidelines, practice guidelines and evidence-based practices for child/adolescent, adult, substance abuse services, and other populations
- Mechanisms in place to determine consistency of guidelines application and decision making, such as inter-rater reliability processes for nursing and physician staff

- Emergency department policies and provisions for providing emergency services (in or out of network) and post stabilization services. Also, implement an educational process for teaching members when to use ER versus PCP.
- Policies addressing types of denials, members rights while denials are pending, monitoring compliance to timelines, notices, and peer review
- Process to analyze high cost high volume procedures and implement a care management program which may include disease management to improve outcomes

Care Coordination

- Care continuity, coordination, and discharge planning
- Role of the provider or PCP in care coordination
- Continuity of care for Special Health Care Needs enrollee
- Implement mixed services protocol; coordinate with medical vendor regarding cases that have behavioral health and physical health components
- Representation on the Pharmacy Managed Care Committee
- Interagency coordination
- Other support services
- Referral follow up
- Emergency departments
- Member access to specialty care adequate to their condition and in some cases allow specialists to function as PCP

Clinical Management

- Intensive care management, including criteria and automated identification of individuals appropriate for program inclusion
- Facilitating family involvement when appropriate
- Case management programs targeting enrollee needs may include specialty, and complex case management
- Enrollee and provider education processes
- Integration of Care Management components, such as UM, CM and DM
- Health Risk Assessment processes and procedures

Provider Relations and Management

- Credentialing
- Provider contracting, including compliance with expectations including access requirements
- Training and orientation
- Provider profiling
- Provider communications (e.g., provider handbook, newsletter, articles, website)
- Site visits
- Managed care readiness assessments
- Provider inquiries and complaints
- Process for oversight of any delegated credentialing agencies
- Provider orientation and education

Member Services

- Enrollment and disenrollment services
- Call management and responsiveness plan; performance requirements
- Member brochure and handbook
- Provider search capabilities
- Member training and orientation
- Cultural competency initiatives
  - Service access for the hearing the impaired and visually challenged and other disabilities in accordance with the Americans with Disabilities Act; and
  - Requirements for interpretation and written documents in identified languages.

Complaints, Grievances and Appeals

Responsibility for:

- Notices
- Complaints and grievances
- Appeals
- Peer review
- Administrative hearings

- Timely and accurate responses, performance requirements
- Process in place to log or track complaints, grievances and appeals and ability to demonstrate analysis and improvement.

Community Liaison

- Conduct town halls or participate in providing information and education to the community
- Meet with advocacy groups
- Develop advisory committees that include consumers, families, advocates, and/or providers
- Collaborate on development of community-based resources
- Facilitate enrollee needs and resolve concerns

Claims Processing

- Coordination of benefits
- Timely claims payment and performance requirements
- Accurate claims payment and performance requirements

Systems

- Data management and accuracy
- Date security and storage
- Disaster recovery
- Interface with existing systems, including medical management systems

Eligibility

- Verification
- Reporting
- Outreach

Reporting and Audit Requirements

- Claims reporting
- Quality improvement reporting
- Consent decree compliance reporting
- Customer Service Reporting
- Network Reporting

- Utilization Reporting
- Complaint, appeals and grievance reporting

Managed Care Organization Structure and Performance

- Care management policy manual development
- Staff credentials, training and monitoring
- Medical record storage, maintenance and release
- Performance guarantees
- Coordination with the County
- Transition processes
- Adequate infrastructure and staffing ratios
- Implementation plan
- Identify and obtain possible funding sources for non-Medicaid services
- Sales, marketing strategy and plan that meets Medicaid requirements

Compliance

- Health Insurance Portability and Accountability Act privacy and security
- Fraud and abuse audits
- Disaster planning and recovery
- Data storage and security
- Medical records
- Advance Directives
- Process to assure that all enrollee and marketing materials are reviewed and approved by DSS

10

Another Model to Consider

As the County moves forward in implementing a model to care for the uninsured, there will likely still be a segment of the working population without health care insurance. Assuming that with available funds, Leon County is able to fund and provide health care to those meeting certain income requirements, there will be a subset of people earning an income above the eligibility threshold for county-sponsored insurance. Another model the County may want to consider for this population is a Three Share Model (also known as Employer Sponsored Insurance). Health care premiums are paid by three groups:

- Employers,
- Employees, and
- A third-party payer (in this case Leon County).

This model targets a working uninsured population which has some resources to pay a share of premiums as well as any cost-sharing, such as co-pays or deductibles. This product could become part of the County's program in terms of providing care for the uninsured. While it covers a more targeted population – the working uninsured meeting certain income requirements – it would not be suited for the general uninsured population, as many are not employed or would not have enough resources to meet either the health care premium or cost-sharing requirements.

Additionally, this model will require infrastructure to help track eligibility requirements, premium funding and member cost-sharing. This infrastructure is most readily available from an ASO or HMO vendor. Assuming the County employs an ASO model for the initiative discussed in the report, this will provide the flexibility to add a Three Share model at a future date.

This type of arrangement has been implemented at the state and county level in different parts of the country. Two examples are the Dirigo Program in Maine and the Muskegon, Michigan Program.

Dirigo Program[40]

The Dirigo Health Reform Act seeks to address health care costs, quality, and access. In order to address access, the Act authorizes the creation of the Dirigo Health Agency to design and administer a voluntary market-based health plan to help small businesses, the self-employed, and individuals afford health coverage. The Act envisioned that the health plan would be offered by a private insurance company or be self-administered and that workers and individuals who meet income guidelines would receive financial assistance to participate in the program.

DirigoChoice™ is designed to provide Maine businesses with 50 or fewer eligible employees, the self-employed, and individuals with an affordable, high-quality option for health coverage. It looks like many health insurance products currently on the market and offers by a private insurance company. The plan competes with private insurers in the small group and individual markets. It must comply with all insurance regulations and attract voluntary participation. However, because DirigoChoice™ is part of a broader initiative to lower health care costs, increase access to health care, and ensure high quality health care, it has some unique features:

- DirigoChoice™ is a public-private collaboration between Maine's Dirigo Health Agency and Anthem Blue Cross and Blue Shield (Anthem) and is coordinated with MaineCare (Maine's Medicaid program, administered by Maine's Department of Health and Human Services), to create a seamless program of health care coverage.
- In addition to emphasizing primary care, DirigoChoice™ includes additional wellness and prevention benefits to improve health and prevent disease and illness.
- State dollars are used to reduce costs for low income enrollees and to cover public administrative and oversight functions.
- Qualified employers and employees share the costs of insurance coverage with the state through monthly payments, annual deductibles, and financial discounts.

DirigoChoice™ is competitively priced and is made more affordable for low wage employees through the discount program. Eligible enrollees will receive discounts on monthly payments and reductions in deductibles and out-of-pocket expenses based on their annual household income. Those with incomes under 300% of FPL (approximately $28,000 for an individual and $56,500 for a family of four in 2004) are eligible for discounts and reduced deductibles and maximum out-of-pocket costs. The discount is available on a sliding scale based on household income (and assets, for Dirigo/MaineCare members). Employees who are eligible for MaineCare receive full discounts and additional services directly from MaineCare.

[40] Excerpted from "Designing Maine's DirigoChoice™ Benefit Plan, Striving to Improve Health at an Affordable Price," developed by NASHP for the Maine Governor's Office of Health Policy and Finance, by Jill Rosenthal and Cynthia Pernice and published in *National Academy for State Health Policy*, December 2004.

DirigoChoice™ will be self-financed through employer and enrollee payments, state general funds, and the federal Medicaid match. In the first year, other state funds have been allocated to cover some administrative costs and enrollee discounts. After year one, state funds will be replaced by an assessment on insurers' gross premium revenues and an assessment on third party administrators. These assessments, or Savings Offset Payments (SOPs), are only levied if and when health care cost savings occur. Health care cost savings are anticipated through coverage of currently uninsured Mainers and a resulting reduction of bad debt and charity care.

Maine spends more than $275 million a year to cover bad debt and charity care, free care to uninsured and underinsured people. The costs are passed on as higher rates from providers and as higher premiums. The Dirigo Health Reform Act proposes to recapture a portion of bad debt and charity care costs and reallocate them to cover the uninsured. Designers of the Dirigo Health Reform Act believe that by providing health coverage to more individuals, preventive care will increase and more costly delayed care will decrease. As a result, under the Reform Act, some of the costs of bad debt, charity care, and other savings achieved through other cost containment measures will be recovered through an assessment on insurers' revenue (SOP). The SOP will be levied only if savings in the health care system can be documented. The funds from the SOP will be reinvested into DirigoChoice™. DirigoChoice™ pools small businesses, the self-employed, and individuals into a large group to better bargain for good prices. As the plan grows over time, so will its capacity to bargain for competitive prices for its members.

The benefit design plan changed significantly from the original proposal to the final product as the result of efforts to design an affordable and acceptable product. One critical change was a shift from requiring a 60% employer contribution for the family premium to the requirement of 60% employer contribution for the employee only.

Access Health of Muskegon, Michigan

Access Health is a "three-share" community-based health plan designed to provide health care coverage to uninsured workers at small firms. It is the stimulus for the proposed federal legislation to federally fund related programs in all fifty states.[41] At the end of 2004, Access Health was serving more than 420 employers and 1,150 employees and collected $2.5 million in premiums from all sources.

Eligibility

- Firms must be headquartered within Muskegon County. Although the program is intended for small employers, there is no upper limit on the size of the firms.

[8] Fronstin and Lee. Health Affairs May/June 2005. See 108th Cong. 2d session, s .2544; and 109th Cong., 1st session S.16.

- Existing employers are eligible if they have not offered health insurance to their employees within the immediate past 12 months. New employers are eligible if they have been in operation for 13 consecutive weeks.
- Sole proprietors are not eligible.
- The median wage of eligible employees in a firm may not exceed $11.50 per hours.
- The employer must pay 30% of the cost of employee-only coverage and may not offer Access Health to retirees, seasonal or temporarily laid-off workers.
- Employees must work 15.5 hours per week over a 13 week period and must be continuously employed for 13 weeks prior to becoming eligible and must be uninsured and not eligible for any other public program.
- Enrolled member with an existing primary care physician are required to have at least one primary care physician visit per year. Members with a "new' primary care physician must schedule a visit within six months.

Benefits

- Coverage includes primary and preventive care.
- Inpatient and outpatient services are covered
- Emergency room visits are covered
- Prescription drugs are covered
- Services are to be provided only within Muskegon County
- Routine Dental, Vision and Hearing Exams are not covered
- Injuries resulting from an automobile accident are not covered
- Organ transplants are not covered
- Members who do not follow recommended treatments or make recommended lifestyle changes may be denied coverage for certain health care services.

Rates

The Access Health benefit package was designed to keep the employee share below $50 per month. In 2004, the employee share was $46.00 per month for Employee-only coverage, an annual increase of 3% since 1999.

Employers are required to pay the same amount as employees, although they are allowed to pay part or all of the employee share, which some do. The community share was $60.24 per month in 2004. The cost of covering a spouse is the same as an employee. The cost for dependent children was $29.29 per month in 2004, with the community share at $39.00 per month. The premium does not vary by age, sex, health status, or geographic region within Muskegon County.

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Overall Recommendations

- *Implement an ASO model to deliver care to the uninsured.* The needs of the uninsured can best be met through an ASO arrangement, which:
  - *Has budget stability and predictability, and minimizes financial risk to the County;*
  - *Mandates that existing clinics currently providing care to the uninsured are part of the primary care network;*
  - *Allows for a strong element of Leon County control and accountability;*
  - *Can be brought to the market in a timely manner, requiring minimal start-up or ramp-up time;*
  - *Avoids crowd-out of other health insurance programs;*
  - *Maximizes existing funding sources;*
  - *Builds on existing best practices and preserves the attributes of the existing program;*
  - *Emphasizes preventive services; and*
  - *Integrates community supports.*
- *Consider implementing a Three-Share model.* This model targets the working uninsured, who have resources to pay a share of premiums and share in other health care costs. Coordinating this approach with the ASO model approach can serve to further decrease the number of uninsured.
- *Merge Bond and NHS.* Merging the clinics under the Bond FQHC umbrella will promote their ability to provide integrated leadership, management infrastructure, and program quality. Additionally, financial support can be enhanced through access to 340B pharmacy pricing and payment for services.

- *Leon County should maintain or increase funding to Bond and NHS.* Both community health centers are critical components of the safety net for Leon County in reducing health disparities for vulnerable populations. Maintaining or increasing funding will enable them to continue to deliver care. Additional funding can assist them in addressing needs such as increasing facility space, expanding professional staff, and establishing an electronic medical record system.
- *To fund this initiative, a ½ cent sales tax should be considered.* A variety of County funding options exist. The ½ cent sales tax is a reasonable option to provide funding to enhance and improve health care for the uninsured.

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